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No. _____

In the Supreme Court of the United States

October Term, 1987

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES OF KANSAS,
Petitioner,

vs.

AMERICARE PROPERTIES, INC.,
d/b/a Russell Kare Center and Ala Fern Nursing Home,
Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF KANSAS

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8 HPV

QUESTIONS PRESENTED FOR REVIEW

1. Are state nursing home licensure laws properly preempted by an interpretation of 42 C.F.R. 442.14 (a) for assignment of Medicaid provider agreements without analysis of the Congressional intent behind the federal enabling statute, 42 U.S.C. 1396 d (c) and its requirement to be "licensed under State law"?

PARTIES

The parties are:

Petitioner:
STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES OF KANSAS.

Respondents:
AMERICARE PROPERTIES, INC., d/b/a Russell Kare Center and Ala Fern Nursing Home.

[THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT appeared as *Amicus Curiae* in the Supreme Court of Kansas proceedings.]

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES CITED

CONSTITUTION CITED

STATUTES CITED

REGULATIONS CITED

No. 87-

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PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF KANSAS

The Petitioner, State Department of Social and Rehabilitation Services of Kansas, respectfully prays that a Writ of Certiorari issue to review the judgment and opinion of the Supreme Court of the State of Kansas filed on June 12, 1987 and denied for rehearing on July 9, 1987.

CITATIONS TO THE OPINIONS BELOW

The opinion of the state agency's Chief Hearing Officer of October 30, 1985, and the review decision of the State Appeals Committee on February 7, 1986 appear as Appendix A. The state District Court's decision on review of July 11, 1986, and its letter decision to deny the motion to alter or amend on September 12, 1986, appear as Appendix B. The opinion of the Supreme Court of Kansas, filed on June 12, 1987, reported at 241 Kan. 607, 738 P.2d 450, and its denial of the Motion for Rehearing on July 9, 1987, appear as Appendix C.

JURISDICTION

The judgment of the Supreme Court of Kansas was entered on June 12, 1987. The petitioner's motion for rehearing was denied on July 11, 1986. This petition for writ of certiorari was filed within ninety (90) days of that date. This Court's jurisdiction is invoked pursuant to 28 U.S.C. 1257(3).

CONSTITUTIONAL PROVISIONS, STATUTES AND REGULATIONS INVOLVED

1. Article VI, cl. 2, Constitution of the United States
2. 42 U.S.C. 139a (a)(13)(A)
   42 U.S.C. 1396d(c)
3. Kansas Statutes Annotated 39-926
   Kansas Statutes Annotated 39-928
4. 42 C.F.R. Section 440.150
   42 C.F.R. Section 442.14
   42 C.F.R. Section 447.253(b)(1)(i)
   Kansas Administrative Regulation 28-39-77(d)
   The pertinent texts are set forth in Appendix D.

STATEMENT OF THE CASE

The respondent, Americare Properties, Inc. requested a quasi-judicial, administrative appeal before the appointed Chief Hearing Officer of the petitioner, State Department of Social and Rehabilitation Services of Kansas (SRS). SRS is the designated single state agency for the administration of the Medicaid (42 U.S.C. 1396a et seq.) program in Kansas. Americare Properties challenged the denial of $106,928.29 of Medicaid payments to two of its intermediate care facilities (ICF's), Russell Kare Center and Ala Fern Nursing Home, for a period of October 1, 1984 through November 25, 1984, while the facilities were not licensed by state requirements, including K.S.A. 39-926 and 928, for operation by Americare Properties. During this period the facilities apparently changed staff, did not indicate even the identity or licensure for the administrator of one facility, and first failed and then delayed submitting ownership information.

SRS took the positions that the Medicaid program does not authorize payments for unlicensed nursing homes, that Americare Properties knew and agreed to such requirements in its own contract agreement as the Buyer in provisions for:

> 4.b.ii Duties with Seller and Buyer on closing with regards to escrow arrangement shall obligate Buyers to:
>
> . . .
>
> (B) Maintain at all times all licenses required to operate the facility as an adult care facility.
>
> . . .

5. As a condition procedent, Buyer must obtain approval of the transaction by licensing and other governmental authority.

. . .

10.c. This agreement is made and delivered and is intended to be performed in the State of Kansas and shall be construed and enforced in accordance with the laws of such State.

(Appendix A, pp. A4-A5.)

that the Medicaid provider agreements to be transferred pursuant to 42 C.F.R. 442.14 to the facilities contain the provisions requiring the provider to maintain a licensed status, that 42 C.F.R. 442.14(b) made the requirement applicable to Americare Properties and its failure to meet them made the agreements null and void, and that the licensure requirements should be construed in harmony with the Congressional intents of the Medicaid program.

The Kansas Department of Health and Environment, the state licensure agency, had also notified the Seller by letter at the beginning of the transactions (as the name of the Buyer was not yet known to the agency) that it would be responsible for the operation of the facility until the issuance of a license to the new owners. The new and first licenses to the operations of Americare Properties were not obtained until November 26, 1984. Despite that, Americare Properties had already assumed operations and made staffing changes since September 1.

The matter in the administrative hearing was

submitted on an agreed record with briefs and arguments to the Chief Hearing Officer who issued a decision upholding SRS' actions on October 30, 1985. The federal regulation requirements were construed in harmony with the state licensure requirements. Americare Properties requested review of the decision by the agency's State Appeals Committee and such Committee upheld the decision in an opinion issued on February 7, 1986. (Appendix A, pp. A30-A33.)

Having exhausted the administrative hearing procedures, Americare Properties petitioned for judicial review by the District Court of Shawnee County, Kansas. In a review on the record, Judge Bullock issued a Memorandum Decision and Order on July 11, 1986. (Appendix B, pp. A34-A38.) That decision reversed the agency finding and adopted Americare Properties' position that the state licensure requirements were superseded by 42 C.F.R. 442.14(a). Neither the term "preemption" nor its requirements were actually mentioned by the Court. (The decision also attempted to award attorney fees which were subsequently reversed by the Supreme Court of Kansas and are not in issue here.) SRS filed a timely Motion to Alter or Amend Judgment and pointed out that the conclusions on superseding federal regulations failed to even mention the federal statutes and especially noted 42 U.S.C. 1396d(c). The District Court declined to modify its opinion in a letter order of September 12, 1986. (Appendix B, pp. A39-A40.)

The petitioner, SRS, then appealed to the Court

of Appeals of Kansas. Subsequently the Supreme Court of Kansas took jurisdiction over the appeal on its own motion. The state licensure and Medicaid survey agency, the Kansas Department of Health and Environment, entered the appeal as an Amicus Curiae and briefed the matter in opposition to the District Court's characterization of the licensure requirements.

After briefs and oral argument the Supreme Court of Kansas entered its opinion on June 12, 1987, (Appendix C, pp. A41-A50.) to affirm and essentially quote the District Court ruling that the state licensure requirements were superseded. The state Supreme Court's opinion did add the formal indication that it was a ruling on application of the preemption doctrine.

SRS moved for a rehearing explicitly on the grounds that the decision did not properly apply the preemption doctrine by failing to note the applicable Congressional intent and by failing to note or apply the recent, applicable decisions of the United States Supreme Court in *Louisiana Public Service Comm. v. FCC*, 476 U.S. ——. 106 S.Ct. 1890, 90 L.Ed.2d 369, 382 (1986) and *Hillsborough County v. Automated Med. Labs*, 471 U.S. 105 S.Ct. 2371, 85 L.Ed.2d 714 (1985). The Supreme Court of Kansas summarily denied the motion for rehearing on July 9, 1987, (Appendix C, pp. A51-A52.) and SRS has brought this petition.

REASON FOR GRANTING THE WRIT

THE Decision Below Has Decided A Federal Question Of Statutory Preemption In A Way In Conflict With Appicable Decisions Of This Court.

The Supreme Court of Kansas has rendered a decision on application of the preemption doctrine while failing to note or undertake the critical analysis of Congressional intent. Neither the opinion of the Supreme Court of Kansas, nor the affirmed and quoted opinion of the state District Court consider the provisions of 42 U.S.C. 1396d(c) and its recognition of the requirement to be "licensed under State law" before construing a subordinate federal regulation to supersede state law licensure requirements.

Americare Properties' facilities, Russell Kare Center and Ala Fern Nursing Home, attempted to participate as intermediate care facilities in the Medicaid program. 42 U.S.C. 1396d(c) defines "intermediate care facility" for the purposes of the Medicaid program:

> For purposes of this subchapter the term "intermediate care facility" means an institution which (1) is *licensed under state law* to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, . . .
> (Emphasis added.)

Despite, and without addressing such a basic statutory program requirement, the Supreme Court of Kansas considered only particular *regulation* intents to rule that 42 C.F.R. 442.14 and its subsection (a) superseded state law licensure requirements and to order Medicaid payments to the facilities although they were not being operated as "licensed under State law."

This Court has recently noted in *Louisiana Public Service Comm. v. FCC*, 476 U.S. ——, 106 S. Ct. 1890, 1899, 90 L.Ed.2d 369, 382 (1986) that: "The critical question in any pre-emption analysis is always whether Congress intended that federal regulation supersede state law." That question has not been applied in this preemption application as the state Supreme Court's decision omits it and the rehearing denial still declines the question.

This Court has also recently noted in *Hillsborough County v. Automated Med. Labs*, 471 U.S. 707, 715, 105 S.Ct. 2371, 2376, 85 L.Ed.2d 714, 722 (1985) that:

> The second obstacle in appellee's path is the presumption that state or local regulation of matters related to health and safety is not invalidated under the Supremacy Clause. . . .

The state Supreme Court's rehearing denial declines to address any such presumption. It should be apparent, however, that state adult care home licensure laws clearly relate to health and safety.

Application of appropriate preemption consider-

ation is the controlling issue of this matter. And the misapplication here should be apparent from the necessary questions of Congressional intent.

As already noted the Medicaid Act through 42 U.S.C. 1396d(c) specifically recognizes the requirement that such an "intermediate care facility" be "licensed under state law". That hardly indicates any intent for preemption of state licensure requirements.

The 42 U.S.C. Section 1396d(c) requirements are implemented in regulation form for the Medicaid program by the Department of Health and Human Services (HHS) in 42 C.F.R. Section 440.150:

> (a) "Intermediate care facility services, other than in an institution for tuberculosis or mental diseases" means services provided in a facility that—
>
> (1) Fully meets the requirements for a State license to provide, on a regular basis, health-related services to individuals who do not require hospital or skilled nursing care, but whose mental or physical condition requires services that—
>
> (i) Are above the level of room and board; and
>
> (ii) Can be made available only through institutional facilities;

The regulation has even added the phrase "Fully meets" to the state licensure requirements.

The state Supreme Court's decision does not note or address those requirements but relies solely on another regulation, 42 C.F.R. Section 442.14(a)

(1986). (The 1986 date is incorrect, but the regulation did not change from the proper, 1984, period.) 42 C.F.R. Section 442.14(a) provides and provided:

> *Assignment of agreement.* When there is a change of ownership, the Medicaid agency must automatically assign the agreement to the new owner.

42 C.F.R. Section 442.14 also has a subsection (b) which the state Supreme Court only generally noted that:

> Additionally, the federal regulation provides that assigned agreements are subject to all applicable statutes and regulations and to the terms and conditions under which the original agreement was issued. The purpose of the federal regulation is to provide continuity of coverage for beneficiaries and recipients, whenever there is a change of ownership. See federal comments accompanying the publication of 42 C.F.R. Section 442.14. 45 Fed. Reg. 22, 935 (1980).
> (241 Kan. at 610, Appendix C, p. A47.)

A look at the actual language of 42 C.F.R. Section 442.14(b) and of the federal agency comments at its adoption shows that neither supports any preemption of state law licensure requirements.

42 C.F.R. Section 442.14(b) provides and provided:

> *Conditions that apply to assigned agreements.* An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued, including but not limited to, the following:
> (1) Any existing plan of correction.

(2) Any expiration date.
(3) Compliance with applicable health and safety standards.
(4) Compliance with the ownership and financial interest disclosure requirements of Sections 455.104 and 455.105 of this chapter.
(5) Compliance with civil rights requirements set forth in 45 C.F.R. Parts 80, 84, and 90.
(6) Compliance with any additional requirements imposed by the Medicaid agency.

Such provisions extensively limit the automatic transfers and clearly recognize applications of licensure requirements on both the federal and state statutory levels as well as through the health and safety standard requirements. A comparison of the final regulation with the earlier Announcement of 4110-35-M and the first regulation proposals in 44 F.R. 6958-6960 (Feb. 5, 1979) indicates an increased recognition by the federal agency of the state requirements.

The state Supreme Court's decision does note a portion of the federal agency's later comments in promulgating the regulation in 45 F.R. 22,935 (Apr. 4, 1980). Part of that comment when considered with the statutory language of 42 U.S.C. 1396d(c) should be controlling. The particular comment is that: "It must be remembered that this regulation refers to transfers of provider agreements and not to transfers of State licenses." Thus, there is clearly neither Congressional nor federal agency intent for any preemption of the Kansas statutory restriction against transfers of licenses in K.S.A. 39-928 that: " . . . Each

license shall be issued only for the premises and persons named in the application and shall not be transferable or assignable. . . ."

Without transfer of licenses the Americare Properties' facilities were clearly not licensed for the October 1, through November 25, 1984, period and that the Kansas statutory provision of K.S.A. 39-926 should have applied.

> K.S.A. 39-926. *License required to operate home; compliance with regulations.* It shall be unlawful for any person or persons acting jointly or severally to operate an adult care home within this state except upon license first had and obtained for that purpose from the secretary of health and environment as the licensing agency upon application made therefore as provided in this act, and compliance with the requirements, standards, rules and regulations, promulgated under its provisions.

With that state law licensure requirement clearly made applicable through both 42 U.S.C. Section 1396d(c) and 42 C.F.R. Section 440.150 no Medicaid payments, nor any other state payments, should be required. As the Court noted in *Harris v. McRae*, 448 U.S. 297, 308-309, 100 S.Ct. 2671, 2684, 65 L.Ed.2d 784, 799 (1980):

> . . . The cornerstone of Medicaid is financial contribution by both the Federal Government and the participating State. Nothing in Title XIX as originally enacted, or in its legislative history, suggests that Congress intended to require a participating State to assume the full costs of providing any health services in its Medicaid plan. Quite the contrary, the purpose of Congress in

> enacting Title XIX was to provide federal financial assistance for all legitimate state expenditures under an approved Medicaid plan. . . .

A preemption of the very state licensure standards recognized in the Medicaid Act does not create any legitimate state expenditure.

Such preemption is also at cross purposes with the required standards of the Medicaid program. As noted in *Pennhurst State School and Hospital v. Halderman*, et al., 451 U.S. 1, 101 S.Ct. 1531, 67 L.Ed.2d 694 (1981), federal standards do not apply beyond programs funded by federal dollars. So the preemption here could not apply to the care of other non Medicaid patients by the Americare Properties' facilities during the same unlicensed period. For those treatments the services would still appear to be unlawful under the state law licensure requirements. Thus the preemption does not operate to the protection of Medicaid recipients. Rather it leaves them without the protection of basic licensure requirements that are to be accorded to all other nursing home patients in the state. This is contrary to the 42 U.S.C. 1396d(c) requirement for an "intermediate care facility" to be "licensed under state law" and the payment implementation of those provisions under 42 U.S.C. 1396a(a) that:

> A State plan for medical assistance must—
>
> . . .
>
> (13) provide—
>
> A. for payment . . . of . . . intermediate care facility services provided under the plan . . .

Unlicensed services are not to be covered under the plan. 42 U.S.C. 1396a(a)(13)(A) is implemented in regulation in 42 C.F.R. Part 447, Subpart C and especially 42 C.F.R. Section 447.253(b)(1) requiring findings for:

> (1) *Payment rates.* (i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide *services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.* (Emphasis added.)

None of this statutory and regulation framework indicates either an intent to preempt State licensure laws or to deprive Medicaid recipients of their protections from such laws.

Preemption has been inappropriately applied in this matter as a means of ordering payment to a provider who has not met Medicaid requirements. The comments of this Court in *Heckler v. Community Health Services of Crawford County, Inc.*, 467 U.S. 51, 104 S.Ct. 2218, 81 L.Ed.2d 42 (1984), although directed to the Medicare program, are in this instance equally applicable to the Medicaid program:

> Justice Holmes wrote: "Men must turn square corners when they deal with the government." *Rock Island, A. & L R. Co. v. United States*, 254 U.S. 141, 143, 41 S.Ct. 55, 56, 65 L.Ed. 188 (1920). This observation has its greatest force when a private party seeks to spend the Government's money. Protection of the public fisc re-

> quires that those who seek public funds act with scrupulous regard for the requirements of law; respondent could expect no less than to be held to the most demanding standards in its quest for public funds. . . . (467 U.S. at 63, 104 S.Ct. at 2225, 81 L.Ed.2d at 54.)

The public funds involved here from the Medicaid program should not be misapplied to services which clearly fail to meet basic federal standards for the medicaid plan.

The failure to meet those requirements was known here to Americare Properties by its purchase agreement and its actions even before it took over the facilities. Indeed, if the Supreme Court of Kansas had applied the state regulation, of and as urged by the Kansas Department of Health and Environment of Kansas, in Administrative Regulation 28-39-77(d):

> Change in ownership. Each licensee shall notify the licensing agency of any anticipated information which differs from that on the current license application form. This notice shall be submitted 60 days in advance of the proposed effective date of the change. *A change of ownership shall not take effect prior to the issuance of a license to the new owner by the licensing agency.* (Emphasis added.)

there would be no change of ownership prior to November 26, 1984, to trigger any assignment of any Medicaid provider agreements to Americare Properties under 42 C.F.R. Section 442.14(a). Americare Properties would not even be a real party in interest in the matter of payment issues prior to November 26, 1984. Of course, there would also be no proper preemption application.

CONCLUSION

In *Louisiana Public Service Comm. v. F.C.C.*, *supra*, 476 U.S. at ——, 106 S.Ct. at 1901, 90 L.Ed.2d at 385, this Court noted that:

> . . . While it is certainly true, and a basic underpinning of our federal system, that state regulation will be displaced to the extent that it stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress, *Hines*, 312 US, at 67, 85 L Ed 581, 61 S Ct 399, it is also true that a federal agency may pre-empt state law only when and if it is acting within the scope of its congressionally delegated authority. This is true for at least two reasons. First, an agency literally has no power to act, let alone pre-empt the validly enacted legislation of a sovereign state, unless and until Congress confers power upon it. Second, the best way of determing whether Congress intended the regulations of an administrative agency to displace state law is to examine the nature and scope of the authority granted by Congress to the agency. . . .

When that examination of Congressional intent and of federal agency implementation is actually made in this matter it should be apparent that neither Congress nor the federal agency involved intended or even envisioned any preemption of State law licensure requirements. Indeed, those requirements are so adopted by and intertwined with the Medicaid program that any preemption of them is itself a thwarting of basic standards and intents of the program.

The Petitioner prays that a Writ of Certiorari be granted and that the decision of the Supreme Court of Kansas be reversed and remanded for further consideration in light of *Louisiana Public Service Comm. v. FCC*, 476 U.S. ——, 106 S.Ct. 1890, 90 L.Ed.2d 369 (1986) and *Hillsborough County v. Automated Med. Labs*, 471 U.S. 707, 105 S.Ct. 2371, 85 L.Ed.2d 714 (1985).

Respectfully submitted,

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APPENDIX TABLE OF CONTENTS

APPENDIX A

Re: Americare Properties, Inc.
AlaFern Nursing Home
Appeal No. 85P0059 (MR)
and Russell Kare Center
Appeal No. 85P0060 (MR)

DECISION

Statement of Case

This is a consolidated appeal from the decision of the Adult Care Home Section, Division of Medical Programs, Kansas Department of Social and Rehabilitation Services to deny payment of Medicaid Reimbursement to Russell Kare Center and AlaFern Nursing Home. Both properties are located in Russell, Kansas and are owned by Americare Properties, Inc. The appellants are the facilities, Russell Kare Center 85P0060 and AlaFern Nursing Home 85P0059.

A request for fair hearing was received by the Administrative Hearings Section of S.R.S. on December 10, 1984. A fair hearing was set for February 13, 1984. The hearing of February 13, 1985 commenced as scheduled. Bruce Hillis, Secretary of Americare Properties, Inc., appeared on behalf of the appellants. Bruce Roby, attorney at law, appeared on behalf of the respondent. During the course of the hearing, Bruce Hillis requested a continuance to allow him to retain counsel. The request was granted. Thereafter, Eugene Hackler, attorney at law, was retained by the appellant. Prehearing conferences

were conducted on May 15, 1985, May 30, 1985 and July 25, 1985. Counsel agreed an evidentary hearing was not necessary and submitted a written record of 433 pages on August 9, 1985. Counsel, thereafter, submitted briefs on the matter. Oral arguments on the briefs were heard on September 30, 1985. The total amount in controversy is $106,928.29.

Findings of Fact

This case involves two intermediate care homes: Russell Kare Center and AlaFern Nursing Home. Prior to September 30, 1984, Russell Kare Home was owned by Alph Co., Inc. and Patrick Burke while AlaFern Nursing Home was owned by Charles A. and Eula Fern Gage. Both facilities were conveyed to Americare Properties, Inc. on September 30, 1984.

Russell Kare Home was licensed by the Kansas Department of Health and Environment (KDHE), effective on July 1, 1984 and expiring on June 30, 1985, for 80 intermediate care beds. The licensees were Alph Co., Inc., owner of the premises, and Patrick Burke, owner of the nursing home business. A provider agreement was also issued to Russell Kare Center for the same time period subject to correctable deficiences before November 30, 1984. Such deficiences were corrected as evidenced by a letter to Russell Kare Center from respondent. (R 290).

AlaFern Nursing Home was licensed by KDHE, effective on June 1, 1984 and expiring on March 31, 1985, for 46 intermediate care beds. The licensees

were Charles A. and Eula Fern Gage. A provider agreement was also issued to AlaFern for the same period subject to correctable deficiencies before October 31, 1984. On October 25, 1984, AlaFern Nursing Home was advised by the respondent that the conditional terms of the agreement were no longer in effect due to the correction of all deficiencies. (R 84).

The prior owners of both Russell Kare Center and AlaFern Nursing Home advised the KDHE by letter, dated August 31, 1984, of the impending sale and change of ownership of the two homes. (R 190). The letter was signed by Charles A. Gage. On September 10, 1985, Gerald A. Block of KDHE replied by letter to Mr. Gage and indicated:

> In regard to the proposed change of ownership of your facility, please be advised that a new applicant may not be licensed to operate an adult care home until all of the required applications including fee, financial statements, resumes, legal documents and plan of correction have been submitted and approved by our office.
>
> *As the current operator, you will be responsible for the operation of the facility until we issue a license to the new operators.* We will send you a copy of the licensure letter when a license is issued to the new operators.
>
> An onsite evaluation will be made to determine any deficiencies of existing facility according to new regulations.
>
> We appreciate your cooperation with our program. If you have any questions, please contact our office.
>
> (R 191 emphasis added.)

An Agreement for Purchase and Sale was entered into on September 25, 1985 for the sale and purchase of Russell Kare Center and for a lease with the option to buy AlaFern Nursing Home. Alph Co., Charles A. Gage and Eula Fern Gage were "Sellers" and Americare Properties, Inc. was the "Buyer". Richard H. Montgomery was "Guarantor". Richard H. Montgomery executed the Agreement as President for Americare Properties, Inc. (R 361-374). A Collateral Assignment of Lease was executed on September 28, 1984 (R 375-382). An Assignment of Lease and Assumption Agreement was executed September 28, 1984. (R 386-390). A Management Service Agreement was agreed to on September 30, 1984 between Americare Systems, Inc. and AlaFern Nursing Home. (R 392-395.) The change of ownership took place on September 30, 1984 for Russell Kare Center as reflected in a letter to respondent from Pamela M. Hesselrode, Executive Secretary of Americare Systems, Inc. (R 202).

The Agreement for Purchase and Sale provides:

> 4.b.ii Duties of Seller and Buyer on closing with regards to escrow arrangement shall obligate Buyers to:
>
> . . .
>
> (B) Maintain at all times all licenses required to operate the facility as an adult care facility.
>
> . . .
>
> 4.c.i. Seller[s. Alphco, Inc. and Charles A. and Eula Fern Gage] shall prior to closing advise the Department of Health and Environment of the Agreement to sell

the Property to Americare Properties, Inc. and request a Change of Ownership survey and advise the Department of Social and Rehabilitative [sic] Services that a new medicaid provider will be acquiring the Property. . . .

. . .

5. As a condition precedent, Buyer must obtain approval of the transaction by licensing and other governmental authority.

. . .

10. The following shall apply to this agreement:

. . .

b. All representation and warranties expressly set out in this Agreement shall survive the closing.

c. This agreement is made and delivered and is intended to be performed in the State of Kansas and shall be construed and enforced in accordance with the laws of such State.

d. Sellers and Buyer represent and warrant that they have authority to perform the terms of this Agreement.

(R 361-374).

On October 1, 1984, Pamela Hesselrode called the respondent requesting the applications needed for executing the change of ownership. The respondent sent a form letter enclosing a provider application to Americare Systems, Inc. A Kansas Medicaid Provider Application for Russell Kare Center was received by the respondent on October 16, 1984. (R 202).

On October 24, 1985, Richard Montgomery and Patrick Burke wrote KDHE enclosing the Change

of Ownership Plan for Russell Kare Center. (R 197). On that same day, KDHE processed a HCFA-1539 to change the bed capacity from 80 to 64 for Russell Kare Center.

On October 30, 1984, KDHE sent letters by certified mail to Charles Gage, Robert Earnest, City Attorney of Russell, Kansas, the Union Bank of East St. Louis, and the First National Bank of Sikeston. The letters informed the addressees to:

> Please be advised that the change of ownership at the Russell Kare Center, and Ala Fern Nursing Home, Russell *has not* been approved. Therefore, the facility is apparently being operated illegally.
> We must receive a licensure and approve that application before issuing a license to a new licensee operating a facility. We are lacking all items on the attached form.
> . . . (R 203-210)

On November 1, 1984, Gerald Block of KDHE called the respondent agency and left a message indicating that the Russell Kare Center and AlaFern Nursing Home were being operated without a license. The respondent then took necessary action to withhold October service checks for the two facilities. (R 212).

On November 2, 1984, Jack Gumb wrote Americare Properties, Inc. to advise that:

> This letter is to officially inform you that the Kansas Medicaid Program does not reimburse for adult care homes who are not licensed by the Department of Health & Environment.

> It is our understanding that you took over the management of these homes on 9/30/84. We will not reimburse for services after that date until you are licensed.
>
> If you disagree with this action, you may file an appeal with the Administrative Appeals Section, 5th Floor, State Office Building, Topeka, Kansas 66612.
>
> (R 211).

On November 5, 1984, an application for an adult care home license for Russell Kare Center and for AlaFern Nursing Home was signed by Bruce Hillis. The application was received by KDHE on November 8, 1984. On November 10, 1984, Gerald Block of KDHE wrote to Bruce Hillis requesting more information about both homes. (R 217). Americare submitted the requested information on November 15, 1984. (R 218). On November 19, 1984, the Notification of Change of Administrator form for AlaFern was mailed to KDHE. Helen Janes was listed as the new administrator effective November 12, 1984. (R 132).

On November 21, 1984, the signed Disclosing Entity Forms for AlaFern Nursing Home and Russell Kare Center were mailed to KDHE. (R 128, 220). The forms were received on November 26, 1984. A license was then issued for AlaFern Nursing Home from November 26, 1984 to March 31, 1985. (R 133). A short term license was also issued for Russell Kare Center from November 26, 1984 to June 30, 1985. (R 222).

The Change of Ownership Plan of Correction for

Russell Kare was mailed to KDHE on November 29, 1984. (R 225).

The Provider Agreement, throughout all of the dates referenced in the Findings of Fact, has included in part that:

> The Provider agrees to maintain standards for participation in the Kansas Medicaid/Medikan Program as provided in all federal and state laws and regulations affecting and implementing said program. The Provider agrees to maintain a licensed status by the State Department of Health and Environment of Kansas in a category as appropriate for participation in the program.
>
> (R 98, 140, 178, 252).

On November 28, 1984, Patrick D. Burke of the Russell Kare Center sent the following memo to Bruce Hillis of Americare:

> On 11-26-84 I called Bruce Hillis to express my concern on the delay of the S.R.S. payment for the Ala Fern and Russell Kare Center for the month of October. Mr. Hillis requested that I call J. Gumb to ascertain as to why the delay. I called on that day, but he was not in. I called again on 11-27-84 and Mr. Gumb's remark was that a check could not be issued because Health and Environment had not issued a license. I then asked when H. & E. did issue the license, would the reimbursement be for the full month of October? He said reimbursement would only be from the effective date of the license. I then called Gerald Block of H. & E. to inquire as to the delay of the license. He told me that Americare had

sent the required papers and were received on 11-26-84, so the effective day of the license would be 11-26-84. I then asked Mr. Block if he was aware that S.R.S would only reimburse from the effective date of the license, his response was yes. I asked him if he thought that was fair and he replied who was the owner of the facility for October? I replied Americare. He then said whose name is on the license now? I said mine. He then said that Americare was operating a facility unlicensed for October and a portion of November. Knowing that this was going to be a controversy, I informed Mr. Block that further conversation will follow, end of conversation. I then called Americare to inform Richard or Bruce but was told that both were out of the office. I called again on 11-28-84 and informed Richard of the matter, he requested that I contact Bruce. Bruce informed me to contact another facility which undertook a change of ownership and also call Dick Hummell of K.H.C.A. I called Lucas Nursing Home (purchased by Beverly), I talked to Celia Anschutz, Adm. I asked her the date of sale for that facility, she replied September 30. I ask her the date of her new license, she replied October 24. I then asked if she was aware that the 23 days would not be reimbursed, she replied yes. I then called Dick Hummell and informed him of the situation. He had not heard of any instances but would research the matter.

(R 223).

On December 7, 1984, Patrick Burke of Russell Kare Center wrote to Bruce Hillis of Americare that:

On 12-6-84, I received the first official notice

> that the days from October 1, 1984 to November 25, 1984 would not be reimbursable.
>
> This notice came via a telephone call from Shelly Welsh of E.D.S. Mrs. Welsh also informed me of the new provider number which is:
>
> 420774
>
> (R 228).

The request for an Administrative fair hearing, dated December 7, 1984, from Richard Montgomery, states as follows:

> By this letter we would like to request an Administrative Appeal on the findings concerning the non-paid Medicaid reimbursement in question for AlaFern Nursing Home and Russell Kare Center.
>
> As you will note on the enclosed copy of a letter dated November 2, 1984 Mr. Gumb informed us that "we will not reimburse for services after that date (9/30/84) until you are licensed". This implied that when our license was issued we would be reimbursed from 9/30/84 to the license date.
>
> Mr. Pat Burke, Administrator at Russell Kare Center, was informed on November 27, 1984, per a phone conversation with Mr. Jack Gumb, that we would not be reimbursed for the date 10/1/84 to 11/26/84. Mr. Burke then informed us of the situation. Therefore, we were correctly informed of the problem approximately ten (10) days ago.
>
> . . .
>
> (R 229).

On December 14, 1984, Bruce Hillis, President of Americare Systems, Inc., wrote two letters to

Jack Gumb of Adult Services of S.R.S. One letter stated that:

> During the course of our telephone conversation of December 6, 1984 I indicated that I had interpreted the following portion of your letter on November 2, 1984 ("we will not reimburse for services after that date until you are licensed") to mean that as soon as we were licensed that reimbursement for the period from September 30, 1984 to the date of licensure would be paid to us.
>
> You stated that you would issue another letter to avoid any possibility of lapsing of my appeal rights. I have not as of this letter received such a letter.
>
> (R 231).

The other letter of the same date stated that:

> I respectfully request that you advise me on what date between September 30, 1984 and November 26, 1984 that either of the above referenced facilities was operating without a Medicaid Provider Agreement.
>
> I also request that you provide me with any notice that was transmitted to either of the referenced facilities in connection with any termination or cancellation of the Provider Agreement together with a copy of the applicable section of the State and or Federal Regulations granting the authority for such termination.
>
> (R 268).

A letter, very similar in text was also sent by Bruce Hillis to Gerald Block on the same date. (R 232).

On December 21, 1984, Jack Gumb wrote to Bruce Hillis explaining that:

> Kansas Adult Care Provider Bulletin dated March, 1984 states, "Effecitive sic, March 15, 1984, SRS will not reimburse services in adult care homes not licensed by the Department of Health and Environment (H & E). This policy, consistent with Kansas law, requires that in cases of ownership change the new owner cannot be reimbursed for any days which follow ownership change that are prior to relicensure by H & E." (Attachment 10.)
>
> It is my understanding that the change of ownership and take over of operations took place on October 1, 1984. The Department of Health and Environment licensed these two facilities on November 26, 1984. This means that the Department will not reimburse for services from October 1, 1984, to November 26, 1984.
>
> . . .

(R 233).

On January 7, 1985, Jack Gumb wrote two more letters to Bruce Hillis. One stated:

> This letter is responding to your letter of December 14, 1984.
>
> These two facilities had a provider agreement between the dates you asked for. The issue is Americare was operating these two facilities and did not have a license by the Department of Health and Environment. A provider agreement is not valid without a license. No letter of termination was sent to the facilities. Your actions of taking over these two facilities without a license made the previous provider

> agreements null and void. I have sent you the regulation sites [sic] in my last letter.
>
> (R 267).

A copy of this letter was sent to Gerald Block of KDHE. The other letter stated:

> Enclosed are copies of Kansas Administrative Regulations (K.A.R.) 30-10-3 and 30-10-12. Also enclosed are copies of Kansas Statutes Annotated (K.S.A.) 39-923 through 948 which includes the 39-926 I think is what you meant by KS 30-9-26 in your letter.
>
> (R 269).

EDS Federal Corporation is the fiscal intermediary for claims processing for the Kansas Medicaid program (see 42 CFR, Section 433, Subpart C). It issued a Kansas Medicaid—Medikan EDS Federal Bulletin for March, 1984 signed by L. Kathryn Klassen, R.N., M.S., the Director of the Division of Medical Programs SRS and Charles D. Klusner, the Director for Provider Services of EDS Federal Corporation. The first page of that bulletin contains the following provision:

> REIMBURSEMENT RELATED TO OWNERSHIP CHANGES MODIFIED MARCH 15, 1984
>
> Effective March 15, 1984, SRS will not reimburse services in adult care homes not licensed by the Department of Health and Environment (H & E). This policy, consistent with Kansas law, requires that in cases of ownership change the new owner cannot be reimbursed for any days which follow ownership change that are prior to relicensure by H & E.
>
> (R 172, 243).

The bulletin provisions apparently originated through a Policy Memorandum dated February 21, 1984 from L. Kathryn Klassen, Director of Medical Programs, to James S. Hall, EDS-Federal, which was approved by John Schneider, Commissioner of Income Maintenance and Medical Services on February 28, 1984 and was further approved by L. Kathryn Klassen on March 2, 1984. The reason for generating the memo was that:

> Federal regulations require states to transfer the previous owners provider agreement whenever a change of ownership occurs. State regulations require a facility to be relicensed whenever a change of ownership occurs.
>
> Recently, we have had several providers who have called and stated "we took over 2-1-84," and the Dept. of Health & Environment has not licensed their facility because they got motice [sic] of the change the same time SRS did.
>
> Another example is the Sugar Valley Home, Mound City. Wes Worthington was leasing the home and then on 1-3-84 called and stated he purchased the home on 12-29-83. He is essentially not a new provider as such, but he bought the physical plant which denotes a change of ownership and requires a new license and certification. Mr. Worthington has not complied with all the Department of Health and Environment licensure requirements and his facility is not licensed yet. We have sent Mr. Worthington a letter indicating that we would not be making any further Medicaid payments until the facility is licensed by the Department of Health and Environment.

This memo will establish a policy that we not reimburse for days in which a facility under new ownership is not licensed.

(R 170, 171).

A Policy and Procedures Announcement generated by the SRS Division of Income Maintenance and Medical Services on March 14, 1983 concerning Adult Care Home Provider Enrollment provides in part:

. . .

Change of Ownership/Lessee

1. The Adult Care Home Section shall send a letter to the new owner/-lessee with information regarding the necessary forms for enrollment.

2. The forms that need to be completed and returned to Medical Programs are:
   Provider Application
   HCFA-1516
   MS-2005—Adult Care Home Provider Agreement
   Written Utilization Review—(If a skilled facility, the UR Attachment needs to be sent to the Department of Health-Environment)
   MS-2004—Projected Cost Report
   HCFA-1513—Disclosure Statement
   The Adult Care Home needs to send a copy of their admission agreement in for review. (If the adult care home is going to use the previous admission agreement, the agency just needs confirmation).

3. When the above-named forms are completed and returned, the Adult Care Home Section shall send the following forms to

the Department of Health and Environment; Bureau of Field Services for the Scheduling of a survey:

a. A copy of the HCFA-1516
b. A copy of the HCFA-1513
c. A copy of the lease, if it has been submitted.

4. The Adult Care Home Section shall send written confirmation to the tentative provider on whether or not their admission agreement is acceptable. If it is not, the reasons need to be stated. This admission agreement has to be approved prior to entering into a provider agreement. The Department of Health and Environment shall be copied when the admission agreement is acceptable.

5. The following forms shall be sent to the fiscal agent once the confirmation of a change of ownership/lessee has been confirmed:

    a. A copy of the HCFA-1513
    b. An EDSF-MS-1 Form de-activating the old provider number with the *same* date as the EDSF-MS-1 activating the new provider number. For example, if the change of ownership/lessee is effective 5-1-82, both the de-activating EDSF-MS-1 and the activating EDSF-MS-1 would have an effective date of 5-1-82. Also, if because of the change of ownership/lessee there is a name change or change of address, this would also be indicated on the EDSF-MS-1. On all changes of ownerships, it shall be noted on the EDS-MS-1 Form as to whether the new provider did or did not give 60 day notice.

1. If the current (new) owner, *gave* 60 day notice prior to purchasing the nursing home, the fiscal agent will load the *prior* owner with a status code of 05 (inactive). An 05 status will indicate to them (the adjustment unit) that any collections for overpayments (must be in the form of a refund check) or underpayments (claim specific or non-claim payouts) for services prior to the change will be processed against the prior owner.

2. If the current (new) owner did *not* give 60 day notice prior to purchasing the nursing home, the fiscal agent will load the *prior* owner with a status code of 08 (no 60 day notice given). An 08 status will indicate to them (the adjustment unit) that any collections for overpayments (refunds or non-claim recoups) for services prior to the change of ownership will be processed against the current (new) owner. Reference can be made to K.A.R. 30-10-1(4). Under payments (claim specific or non-claim payouts) for services prior to the change of ownership will be processed against the prior owner.

3. Since underpayments go to the previous provider regardless of whether or not a 60 day notice was given, EDS-F shall change the address on the inactive provider number (status code 05) to the previous

owner's address. EDS-F will receive this information via EDS-MSS-1—Form at the time of the deactivation. This will allow an address to send 1099's to.

This form is completed by the Adult Care Home Section Secretary and the Administrator of Financial Management.

c. After all change of ownership/lessee forms have been approved and processed, a letter shall be sent to the facility to document the final completion of the process. (Attachment 2)

6. A memo shall also be sent to Data Processing informing them to change field 425 from the old provider number to the new provider number on all 310T's and the date this becomes effective. (See Attachment 3) (R 296-300).

The Medicare/Medicaid State Operations Manual, Provider Certification, Section 3702 provides that:

A. *Assignment of Provider Agreements*— Assignment of the provider agreement to the new owner assumes continued compliance by him with the program requirements under which the agreement was initially issued, including:

. . .

4. *Disclosure of Ownership and Financial Interest Information.*—
Send the new owner the HCFA-1513. Although disclosure is not a prerequisite to assignment, refusal to submit the required information after assignment will result in termination. Under no circumstances will the new owner

> be certified and issued a new agreement unless disclosure requirements are met.
> . . .
>
> (R 428).

The Minutes of the October 2, 1984 Meeting of the Board of Directors of Americare Systems, Inc. indicate that:

> . . .
> IT IS HEREBY RESOLVED that Ms. Darita Mermis be employed as Interim Administrator at AlaFern Nursing Home, Russell, Kansas and further resolved that Ms. Mermis be impowered to act on behalf of the governing body in connection with all policies and procedures for AlaFern Nursing Home.
> . . .
>
> (R 391).

There is no indication from the record that this action was ever properly reported to KDHE or SRS. Rodney Gage did not advise KDHE that he was no longer acting in the capacity of administrator of AlaFern Nursing Home until November 1, 1984. (R 120).

The Board of Directors of Americare Systems, Inc. also took action that:

> . . .
> IT IS HEREBY RESOLVED that Americare Systems, Inc. enter into a Management Contract with Americare Properties, Inc. d/b/a AlaFern Nursing Home, Russell, Kansas for comprehensive management services provided for AlaFern Nursing Home. Attached is a copy of the management Contract.
> . . .
>
> (R 391).

The attached *Management Services Agreement*, dated

September 30, 1984, is unusual in that Americare Properties, Inc. is not mentioned at all in the agreement and AlaFern is only mentioned in the notices provision. (R 392-395). Exhibit 1 of the Management Agreement is the only other reference that the agreement was entered into by Americare Systems, Inc. and AlaFern Nursing Home. (R 392-395). There is no indication in the record that this action was ever timely reported to KDHE or SRS.

Discussion

The first issue this case presents is whether the request for fair hearing was timely pursuant to K.A.R. 30-7-30(a).

> K.A.R. 30-7-30(a) *Dismissal of request for fair hearing.* A request for fair hearing shall be dismissed if: (a) The request is filed with the agency more than thirty (30) days from the date of decision or request for agency action; . . .

The first notice the appellant received indicating problems with reimbursement for services rendered at the two nursing homes in October of 1984 was the November 2, 1984 letter from Jack Gumb advising Americare that SRS would not reimburse for services after September 30, 1984 "until you are licensed." (R 211).

The appellant argues that the word "until" was interpreted to mean "up to the time that; 'til such

time as" and that due to this interpretation a fair hearing was not requested since payment was anticipated at a later date. (Appellant's Brief, p. 46). In reading the letter of November 2, 1984 the Chief Hearing Officer finds that a reasonable person could have interpretated it as appellant has suggested.

The record reflects that Patrick D. Burke of the Russell Kare Center was advised on November 26, 1984 by Jack Gumb that no reimbursement would be forthcoming. Mr. Burke then contacted Richard Montgomery and Bruce Hillis of the respondent's non-payment decision They were apprised of the situation on November 28, 1985. The action of the respondent was subsequently appealed by a letter dated December 7, 1984 and received by Administrative Hearing Section on December 10, 1984.

Due to the unclear nature of the November 2, 1984 letter, the letter is not considered an agency action in this case which started the 30 days time period to appeal. It was not until November 26, 1984 that an employee of the appellant was advised of the meaning of the November 2, 1984 letter. Therefore, November 26, 1984 is considered to be the date that the appellant had notice of the agency action. The appellant, thereafter, appealed in a timely manner. Thus, the action is properly before this Hearing Officer.

The second issue presented in this case is whether the appellant is entitled to medicaid reimbursement in the amount of $106,938.29.

The appellants assert that they have a contract

right to recover reimbursement for the time period at issue under the old provider agreement between respondent and the two facilities; AlaFern Nursing Home and Russell Kare Center. The provider agreements are standard forms and all provide the following:

> . . .
>
> The Provider agrees to maintain standards for participation in the Kansas Medicaid/MediKan Program as provided in all federal and state laws and regulations affecting and implementing said program. The Provider agrees to maintain a licensed status by the State Department of Health and Environment of Kansas in a category as appropriate for participation in the program.
>
> . . .
>
> Existing provider agreements shall be assigned to the new owners subject to the terms and conditions under which they were originally issued.

(R 98, 140, 178, 252).

Further, 42 C.F.R. 442.14 mandates assignment of provider agreements. It states in pertinent part:

> §442.14 *Effect of change of ownership.*
>
> (a) *Assignment of agreement.* When there is a change of ownership, the Medicaid agency must automatically assign the agreement to the new owner.
>
> . . .
>
> [45 FR 22936, Apr. 4, 1980]

In further support of appellant's position, the

letter from Robert C. Harder, Secretary of SRS, states that the Code of Federal Regulations do allow for assignment and that the Health Care Finance Administration *State Operations Manual—Provider Certification* provides for such assignment.

The respondent persuasively argues that the actions of taking over the facilities without a license makes the provider agreement null and void. K.S.A. 39-926 states:

> *License required to operate home; compliance with regulation.* It shall be unlawful for any person or persons acting jointly or severally to operate an adult care home within this state except upon license first had and obtained for that purpose from the secretary of health and environment as the licensing agency upon application made therefor as provided in this act, and compliance with the requirements, standards, rules and regulations, promulgated under its provisions.

Further, K.S.A. 39-928 states in pertinent part:

> . . . Each license shall be issued only for the premises and persons named in the application and shall not be transferable or assignable. . . .

There is no question that the new owners did not have a license from October 1, 1984 through November 25, 1984. To operate a nursing home without a license is unlawful according to state statutary law. Pursuant to a provider agreement, the provider agrees to maintain a licensed status. When a new provider fails to comply with that requirement, the assigned

provider agreement becomes null and void. Not only did the new providers here fail to meet the conditions of the provider agreement, but they operated the facilities unlawfully. Thus, the general policy of contract law that an unlawful contract is null and void operates to nullify the provider agreement.

42 CFR §442.14 (a) contains mandatory language that the Medicaid agency *must* automatically assign the agreement. However, 42 CFR §442.14 (b) contains numerous conditions that apply to and limit the effectiveness or operation of any such assignment. The assigned agreement remains subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued. These are not limited to federally applicable statutes and regulations and therefore, include applicable state statutes and regulations (eg. K.S.A. 39-928, K.S.A. 39-926 and K.A.R. 28-39-77 (d)).

In summary, the Chief Hearing Officer agrees that the provider agreement were automatically assigned to the new owners. However, once assigned, the provider agreements became null and void due to the non-licensed status of the two facilities.

The Chief Hearing Officer believes this reasoning is contemplated by the federal regulation. The preamble to 42 CFR 442.14 found in 45 F.R. 22935, April 4, 1980. states in pertinent part:

> All providers are required to be in compliance with State and local laws as a condition of participation. If the State, after a licensure

> survey, refuses to issue a license because of non-compliance with State law, the facility would no longer be eligible to participate in the Federal program. It must be remembered that this regulation refers to transfers of provider agreements and not to transfer of State licenses.

The appellants contend that the old owners had provisional licenses and that the old licenses continued when there was not a cancellation of the provisional license, nor an extension of time to meet the requirements of the provisional license or an additional license for the new owner. In support appellant cites the language of K.S.A. 39-929 stating that:

> ". . . a change of ownership during the provisional licensing period will not extend the time for the requirements to be met that were the basis for the provisional license . . ."

implies that new owners continue to operate under the old provisional license. The respondent argues that the licenses were not provisional because provisional licenses are issued for six months while the appellant's licenses were issued for more than six months and, therefore, K.S.A. 39-929 does not apply.

It is unclear whether the old licenses were provisional or not. However it is unnecessary to determine if the licenses were provisional or not because the result is the same. An alleged implication in a statute cannot control over the clear language of a statute. K.S.A. 39-928 clearly states:

> . . . Each license shall be issued only for the premises and persons named in the application

> and shall not be transferable or assignable. . . . (emphasis added)

The Chief Hearing Officer finds that K.S.A. 39-929 simply allows the new owners the same amount of time to correct deficiencies as the old licensees had been allowed.

The appellant further contends that the prior owner's licenses and provider agreements were valid during the time in question, therefore, reimbursement is due on the "old" contract and that the "old" license was not denied, suspended or revoked in the manner required by K.S.A. 39-931. In addition, the appellant argues that the agency failed to comply with the provision of the provider agreement which provides that:

> The Provider and Department mutually agree to allow each other at least fifteen (15) days prior notice in the event of termination of participation in the program; this notice pertains to cessation of business, election to participate in this program no longer, and to transfers of the ownership or operation of said business, to reduction in type of care to be provided by the Provider, or to cancellation of provider agreement by Department. (R 98, 140, 178, 252).

Further, correspondence from KDHE to the appellant indicates that the "old" owners were to continue operating the two homes.

At first glance, the appellant's argument makes sense. However, the appellant overlooks the obvious

fact that the old owners were not operating the homes during the time at issue. The Agreement for Purchase and Sale to buy was executed on or before September 30, 1984. At that point in time, the appellants were the legal owners of the two facilities. The contracts provider agreement, between the old owners and the respondent was no longer operative. The old owners legal status had changed and, technically, was no longer providing services to the Medicaid recipients thus the contracts were no longer operative. Pursuant to federal regulation and the provisions of the provider agreements, they were assigned to the new providers and, thereafter, became null and void because the appellants did not have valid licenses.

The licenses of the old owners were not revoked, cancelled or terminated by KDHE. Notice of such is required only when the licensee has failed to comply with the requirements, standards, or rules and regulations established by K.S.A. Chapter 39, Article 9. Therefore, such notice was not required since the old owners had not failed to comply with any requirement, standard, or rules and regulations. When the "old" owner's ownership status changed the "old" licenses were no longer valid. The licenses were issued to a specific person for a specific facility. When the status of the person changes the license is no longer valid. Therefore, the appellant has no right to recover under the "old" owner's licenses and provider agreements which were no longer valid. Although neither facility was given 15 day notice of cancellation of the provider agreement, the contract

was null and void by operation of law for the aforementioned reasons.

The appellant argues that fairness and justice require that payments be rendered. The appellant contends that the services were rendered in good faith and that SRS has the ethical and moral duty to practice fairness and justice and, therefore, should reimburse the appellant for the services. There is no dispute that the services were rendered. However, the Chief Hearing Officer has very little equitable powers and, as such, cannot invoke equitable powers as suggested by appellant.

The Chief Hearing Officer finds that the appellant was operating the facility without a license which caused the provider agreement to be void. Therefore, the appellant should not be reimbursed for services rendered Medicaid recipients from October 1, 1984 through November 25, 1984.

Conclusion

The respondent's decision is affirmed.

ADMINISTRATIVE HEARINGS SECTION

/s/ Carol L. Foreman
Carol L. Foreman
Chief Hearing Officer
Administrative Hearings Section

Situs: Topeka (Shawnee County)

Hearing Officer: Carol L. Foreman

CERTIFICATE OF SERVICE

I hereby certify that on the 30th day of October, 1985, I caused a true and correct copy of the above and foregoing Notice of Decision of Fair Hearing and the Decision to be deposited in the U.S. mail, first class postage prepaid, addressed as follows:

Eugene T. Hackler
Attorney at Law
One North Court
201 North Cherry
P.O. Box 1
Olathe, Kansas 66061

/s/ Carol L. Foreman
Carol L. Foreman
Chief Hearing Officer
Administrative Hearings Section

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES OF KANSAS NOTICE OF DECISION OF THE STATE APPEALS COMMITTEE

Topeka, Kansas
February 7, 1986

TO: Russell Kare Center, Appellant
AlaFern Nursing Home, Appellant
Eugene T. Hackler, Attorney for Appellants
Kathryn Klassen, Director, Medical Programs
Bruce A. Roby, SRS Attorney
Medical Programs

Please find enclosed the decision of the State Appeals Committee which reviewed the decision of the Hearing Officer.

If the decision is adverse to the appellants' interest, the appellants have a right to appeal the Committee's decision to the District Court under K.S.A. 77-601 et seq.

/s/ Robert C. Harder
Robert C. Harder
Secretary of Social and
Rehabilitation Services

Re: Russell Kare Center and
AlaFern Nursing Home
Appeal No. 85P0060 (MR)
Appeal No. 85P0059 (MR)

STATE APPEALS COMMITTEE DECISION

An initial DECISION was rendered in the fair hearing of Russell Kare Center and AlaFern Nursing Home on October 30, 1985, by Carol L. Foreman, Chief Hearing Officer, Administrative Hearings Section. The ownership of the two facilities changed hands during a period when provider agreements were in effect. After the change of ownership took place, the agency learned from the Kansas Department of Health and Environment (KDHE) that the new owner of the facilities, Americare Properties, Inc. (Americare) was not licensed to operate nursing home facilities. The agency, upon learning of the unlicensed nature of Americare, advised Americare that SRS would not reimburse Americare for services rendered for a period of nearly sixty (60) days in which Americare was not licensed to operate nursing home facilities.

The appellants claimed that Americare was automatically assigned the provider agreements of the previous owners and, therefore, was entitled to reimbursement pursuant to the assigned provider agreements. The Chief Hearing Officer found that the provider agreements were automatically assigned to Americare on the change of ownership, but that

certain conditions apply to and limit the effectiveness or operation of the assignment. One very important condition is that the new owner of a nursing home facility must be licensed by KDHE to operate a nursing home facility at the time of the change of ownership. Since Americare was not licensed at the time of the change of ownership, the Chief Hearing Officer ruled that the provider agreements, once assigned, became null and void due to the unlicensed status of Americare. The Chief Hearing Officer, therefore, affirmed the agency decision not to reimburse Americare for services provided during the period of time Americare was not licensed.

The Appellants requested a State Appeals Committee review on November 19, 1985. Russell Kare Center and AlaFern Nursing Home appeared by and through their attorney, Eugene T. Hackler. The Department of Social and Rehabilitation Services appeared by and through its attorney, Bruce A. Roby.

The original State Appeals Committee rendered its DECISION on December 27, 1985. This DECISION was set aside by the Chief Hearing Officer in an ORDER dated January 10, 1986 because the original State Appeals Committee was improperly composed of a member who had previous input into the case. The State Appeals Committee was reappointed on January 14, 1986.

The reappointed State Appeals Committee has reviewed the record and the Chief Hearing Officer's

DECISION. The Committee now unanimously affirms the Chief Hearing Officer's DECISION and completely and fully adopts the facts and discussion contained therein as its own.

STATE APPEALS COMMITTEE

/s/ Charles Stevenson
Charles Stevenson

/s/ Aileen Whitfill
Aileen Whitfill

/s/ Herman Hafenstein
Herman Hafenstein

Situs: Topeka (Shawnee County)

Hearing Officer: Carol L. Foreman

APPENDIX B

IN THE DISTRICT COURT OF
SHAWNEE COUNTY, KANSAS
SIXTH DIVISION

AMERICARE PROPERTIES, INC. dba RUSSELL KARE CENTER and ALAFERN NURSING HOME, Plaintiff,	)	
v.	)	Case No. 86-CV-94
STATE APPEALS COMMITTEE, KANSAS STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES, Defendants.	)	

MEMORANDUM DECISION AND ORDER

The above-entitled matter comes before the Court for judicial review of an agency action pursuant to K.S.A. 77-601, et seq. Petitioner appeals from the February 7, 1986 decision of the State Appeals Committee, Kansas State Department of Social and Rehabilitation Services (SRS). The SRS refused to reimburse petitioner for services rendered Medicaid recipients at the Russell Kare Center and Alafern Nursing Home from October 1, 1984, through November 25, 1984. On October 1, 1984, petitioner took over ownership of these care homes, but did not obtain a license from the State Department of Health

and Environment until November 25, 1984. As of March 15, 1984, SRS has had the policy of refusing to reimburse new owners for the days their facility is not licensed. Petitioner appealed the SRS refusal of reimbursement. Petitioner pursued its administrative remedies and on February 7, 1986 the State Appeals Committee affirmed the Chief Hearing Officer's decision which ruled in favor of the SRS. The matter comes on now for judicial review:

ISSUES

1. Whether or not a medicaid provider agreement which was automatically assigned to a new owner of a nursing home may be held null and void by the SRS due to the nonlicensed status of the nursing home, resulting in SRS refusal to reimburse for services rendered medicaid recipients during the period of nonlicensure.

2. Whether or not petitioner is entitled to attorneys fees.

CONCLUSIONS OF LAW

1. The scope of review of the district court over an administrative action is stated in K.S.A. 77-621. The issue before the Court concerns respondent's interpretation of the law: Whether or not respondent properly relied on state licensure requirements to rule that a medicaid provider agreement becomes void when it passes to a nonlicensed new owner. The Court may grant relief to petitioners only if it determines "the agency has erroneously interpreted or applied the law." K.S.A. 77-621(c)(4). Petitioner

claims that federal regulations require respondent to pay for medicaid payments totaling $106,928.29 for services rendered to residents of its two nursing homes. Respondent admits to the amount of money involved in the matter but claims it rightfully withheld reimbursement.

Under Kansas law, an adult care home may not operate without a license. K.S.A. 39-926. These licenses are not transferable. K.S.A. 39-928. The federal regulations concerning the transfer of provider agreements state that where an owner of a facility receiving reimbursement for services rendered medicaid recipients under a provider agreement transfers ownership of the facility, the provider agreement is automatically assigned to the new owner. 42 C.F.R. sec. 442.14(a). Respondent claims that in those situations where a new owner had delayed in obtaining a license, the provider agreement automatically transfers to the new owner, but it immediately becomes null and void because of the new owner's nonlicensed status. The Court finds that respondent's method of reconciling the conflict between Kansas law and 42 C.F.R. sec. 442.14 thwarts the purpose of the federal regulation. "A state is not obligated to participate in the medicaid program; however, once it has voluntarily elected to participate, the state must comply with federal standards." *Country Club Home, Inc. v. Harder*, 228 Kan. 756, 763, 620 P.2d 1140 (1980). 42 C.F.R. sec. 442.14 makes reference to the Federal Register, 45 F.R. 22935, Apr. 4, 1980, which comments on the fact that some state laws prohibit transfer of a license to a new owner, so an automatic trans-

fer of a provider agreement would make a state violate its own rules. The Comment responds to this concern by stating that the primary goal of automatic assignment "is to protect beneficiaries and recipients against interruption of coverage." The Comment also states:

> "All providers are required to be in compliance with State and local laws as condition of participation. If the State, after a licensure survey, refuses to issue a license because of noncompliance with State law, the facility would no longer be eligible to participate in the Federal programs. It must be remembered that this regulation refers to transfers of provider agreements and not to transfers of State licenses."

In this case, there was a delay in getting a license, not a refusal of state licensure. The Court finds the automatic transfer regulation clearly applies to the situation where a new owner takes over a nursing home, provides the proper care, but does not receive an automatic license from the state. This is the very situation where beneficiaries and recipients should not be punished for a delay in getting a state license.

The Court finds that the SRS erroneously interpreted the law when it held the provider agreement void in the hands of the new owner. The Court understands that the policy of nonpayment for services rendered while unlicensed was meant to discourage new owners from procrastinating in their compliance of state law upon change of ownership. However, because of 42 C.F.R. sec. 442.14 and its clear intent to guard against interruption of medicaid, the Court

finds the SRS should use other methods to ensure timely compliance with the state licensure law.

Therefore, for the reasons stated above, the Court grants relief to petitioners in the amount of $106,928.29, plus interest and costs.

2. Petitioner also requests attorney fees. Under K.S.A. 77-622(c), the Court may award attorney fees only to the extent expressly authorized by law. Under K.A.R. 30-10-12(b)(4)(A)(ii) providers may get reasonable reimbursements from the agency for some costs not related to patient care. K.A.R. 30-10-12(b)(4)(A)(ii)(cc) states:

> "If a provider appeals the agency's intended action and the final decision is in favor of the provider, costs related to the appeal shall be considered related to patient care."

Pursuant to this regulation, the Court finds attorney fees are costs related to patient care. Therefore, petitioner may apply to the agency for reimbursement for actual attorney fees and expenses incurred pursuant to K.A.R. 30-10-12 and 30-10-13.

This Memorandum Decision and Order shall serve as the Court's order, no further journal entry being required.

/s/ Terry L. Bullock
TERRY L. BULLOCK
District Judge

Dated July 10, 1986
TO: Eugene T. Hackler, Esq.
Bruce A. Roby, Esq.

District Court of Kansas
Third Judicial District
Shawnee County, Kansas

Chambers of
Terry L. Bullock
Judge of the District Court
Division No. Six
Shawnee County Courthouse
Topeka, Kansas 66603

DECISION

September 12, 1986

RE: Americare Properties, Inc.
v. State Appeals Committee, SRS
Case No. 86-CV-94

Counsel:

The Court has considered the defendant's motion to alter and amend judgment in the above-entitled cause, together with the response thereto and is satisfied the same should be overruled in its entirety. The reasons and authorities set forth in the response to the motion are complete and correct and are adopted by the Court as its findings and conclusions in connection with this order.

The Court has also examined the schedule of charges submitted by Mr. Hackler in connection with the

Court's order on attorney fees and finds such charges reasonable and necessary and the same are approved in the amount of $27,409.34. This letter shall serve as the Court's order, no further journal entry being required.

Very truly yours,
/s/ Terry L. Bullock

TO: Eugene T. Hackler, Esq.
Bruce A. Roby, Esq.

APPENDIX C

No. 60,044

AMERICARE PROPERTIES, INC.
d/b/a RUSSELL KARE CENTER
and
ALAFERN NURSING HOME,
Appellees,

v.

STATE DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES,
Appellant.

SYLLABUS BY THE COURT

1.

A state is not obligated to participate in the Medicaid program; however, once it has voluntary elected to participate, the state must comply with federal standards.

2.

Federal law preempts state law to the extent that state law conflicts with federal law. The preemption doctrine applies to regulations as well as statutes.

3.

Under the specific facts of this case, it is held that under the federal automatic transfer regulation, 42 C.F.R. § 442.14(a) (1986), the provider agreements held by the prior owner and operator of two adult care homes were automatically transferred to

the new operator, Americare Properties, Inc.; the provider agreements did not immediately become void in the hands of the new owner; and the new owner, Americare Properties, Inc., is entitled to recover Medicaid reimbursement from the date it commenced operation of the homes to the date its state license was issued.

Appeal from Shawnee district count; TERRY L. BULLOCK, judge.

Opinion filed June 12, 1987. Affirmed in part and reversed in part.

Michael George, chief litigation counsel, argued the cause and *Bruce A. Roby*, of State Department of Social and Rehabilitation Services, was on the briefs for the appellant.

Eugene T. Hackler, of Hackler, Londerholm, Corder, Martin & Hackler, Chartered, of Olathe, argued the cause and was on the briefs for the appellees.

Frank W. Layman, of Topeka, was on the *amicus curiae* brief for the Kansas Department of Health and Environment.

The opinion of the court was delivered by

MILLER, J.: This is an appeal by the State Department of Social and Rehabilitation Services (SRS) from an order of the Shawnee County District Court granting judgment to the plaintiff, Americare Properties, Inc., d/b/a Russell Kare Center and Ala-Fern Nursing Home, in the amount of $106,928.29,

plus interest, costs, and attorney fees. Appeal was timely, and the case was transferred to this court pursuant to K.S.A. 20-3018(c).

The facts are not in dispute. Russell Kare Center and AlaFern Nursing Home are two adult care homes, classified as intermediate care facilities and located in Russell, Kansas. Plaintiff, Americare Properties, Inc., entered into an agreement for the purchase of Russell Kare Center and for the lease with option to buy AlaFern Nursing Home. The change in ownership took place on September 30, 1984. Both transactions constitute a change of ownership under SRS regulation, K.A.R. 30-10-1b (c) (2), (4).

At the time of the transfer, both facilities were covered by provider agreements, which are prerequisites to participation in the federal Medicaid program. Russell Kare Center's provider agreement did not expire until June 30, 1985, and the AlaFern Nursing Home agreement did not expire until March 31, 1985. Both homes were also licensed with the Kansas Department of Health and Environment (KDHE). AlaFern's license extending until March 31, 1985, and Russell Kare's license to June 30, 1985.

Provider agreements are entered into between the adult care facility and the SRS. K.A.R. 30-10-1c. Licenses for adult care homes are issued by the Department of Health and Environment. K.A.R. 28-39-77.

KDHE was notified of the impending sale of both homes on August 31, 1984. On October 1, 1984, im-

mediately after the change in ownership, Americare called SRS and requested all applications necessary for a change of ownership. An exchange of calls and correspondence followed. On October 16, the provider applications were sent to SRS, and on November 5 an application for licensure was directed to the KDHE. Ultimately, on November 26, 1984, a license was issued by KDHE to the new owners for each facility.

SRS refused to reimburse Americare for services rendered between October 1, 1984, the day Americare took over operation of the two homes, and November 26, 1984, the day on which the licenses were issued. As a result of this decision, Americare was denied Medicaid reimbursement in the amount of $106,928.29. On administrative appeal, the Chief Hearing Officer affirmed SRS's decision to deny payment, and the State Appeals Committee affirmed. Americare appealed to the Shawnee County District Court, which reversed the agency decision and allowed Americare to recover the disputed reimbursement. The trial judge aptly stated the reasons for his decisions as follows:

> "The scope of review of the district court over an administrative action is stated in K.S.A. 77-621. The issue before the Court concerns respondent's interpretation of the law: Whether or not respondent properly relied on state licensure requirements to rule that a medicaid provider agreement becomes void when it passes to a nonlicensed new owner. The Court may grant relief to petitioners only

if it determines 'the agency has erroneously interpreted or applied the law.' K.S.A. 77-621(c)(4). Petitioner claims that federal regulations require respondent to pay for medicaid payments totaling $106,928.29 for services rendered to residents of its two nursing homes. Respondent admits to the amount of money involved in the matter but claims it rightfully withheld reimbursement

"Under Kansas law, an adult care home may not operate without a license. K.S.A. 39-926. These licenses are not transferable. K.S.A. 39-928. The federal regulations concerning the transfer of provider agreements state that where an owner of a facility receiving reimbursement for services rendered medicaid recipients under a provider agreement transfers ownership of the facility, the provider agreement is automatically assigned to the new owner. 42 C.F.R. sec. 442.14(a). Respondent claims that in those situations where a new owner had delayed in obtaining a license, the provider agreement automatically transfers to the new owner, but it immediately becomes null and void because of the new owner's nonlicensed status. The Court finds that respondent's method of reconciling the conflict between Kansas law and 42 C.F.R. sec. 442.14 thwarts the purpose of the federal regulation. 'A state is not obligated to participate in the medicaid program; however, once it has voluntarily elected to participate, the state must comply with federal standards.' *Country Club Home, Inc. v. Harder*, 228 Kan. 756, 763, 620 P.2d 1140 (1980). 42 C.F.R. sec. 442.14 makes reference to the Federal Register, 45 F.R. 22935, Apr. 4, 1980, which comments on the fact that some state laws prohibit transfer of a license to a new owner, so

an automatic transfer of a provider agreement would make a state violate its own rules. The Comment responds to this concern by stating that the primary goal of automatic assignment 'is to protect beneficiaries and recipients against interruption of coverage.' The Comment also states:

> " 'All providers are required to be in compliance with State and local laws as condition of participation. If the State, after a licensure survey, refuses to issue a license because of noncompliance with State law, the facility would no longer be eligible to participate in the Federal programs. It must be remembered that this regulation refers to transfers of provider agreements and not to transfers of State licenses.'

In this case, there was a delay in getting a license, not a refusal of state licensure. The Court finds the automatic transfer regulation clearly applies to the situation where a new owner takes over a nursing home, provides the proper care, but does not receive an automatic license from the state. This is the very situation where beneficiaries and recipients should not be punished for a delay in getting a state license.

"The Court finds that the SRS erroneously interpreted the law when it held the provider agreement void in the hands of the new owner. The Court understands that the policy of nonpayment for services rendered while unlicensed was meant to discourage new owners from procrastinating in their compliance of state law upon change of ownership. However, because of 42 C.F.R. sec. 442.14 and its clear intent to guard against interruption of medicaid, the Court finds the SRS should use other

> methods to ensure timely compliance with the state licensure law.
>
> "Therefore, for the reasons stated above, the Court grants relief to petitioners in the amount of $106,928.29, plus interest and costs."

State law, on the one hand, requires a license to operate an adult care home. K.S.A. 39-926. Operating an adult care home without a license subjects the offender to a fine of not more than $100, or imprisonment in a county jail for a period of not more than six months, or both. K.S.A. 39-943. Licenses are not transferable. K.S.A. 39-928. Further, Kansas regulations require new owners to apply for new provider agreements. K.A.R. 30-10-1b(c)(2), (4).

The federal regulation, however, provides as follows:

> "*Assignment of agreement.* When there is a change of ownership, the Medicaid agency must automatically assign the agreement to the new owner." 42 C.F.R. § 442.14(a) (1986).

Additionally, the federal regulation provides that assigned agreements are subject to all applicable statutes and regulations and to the terms and conditions under which the original agreement was issued. The purpose of the federal regulation is to provide continuity of coverage for beneficiaries and recipients, whenever there is a change of ownership. See federal comments accompanying the publication of 42 C.F.R. §442.14. 45 Fed. Reg. 22,935 (1980).

The State reconciled these conflicting statutes and regulations by finding that the provider agreement was automatically assigned, but once assigned, immediately became null and void because of the unlicensed status of the homes.

One of the examples relied upon by the Chief Hearing Officer was an instance in which the operator of a licensed nursing home, who had been leasing the physical property, bought the property. This created a change of ownership, and the home was denied reimbursement for Medicaid services during the period of time between the purchase and the issuance of a new license. It does not appear to us that such procedure comports with the purpose of the federal regulation.

In the case at hand, both Russell Kare Center and AlaFern Nursing Home were licensed and held provider agreements at the time of the transfer of ownership. There is nothing in the record to indicate that either KDHE or SRS inspected the premises during the unlicensed interim period, or that the services to the recipients fell below standards during that time, or that Americare or any of its employees or the homes were unqualified for licensure under any state statute or regulation. The federal regulation requires providers to meet state license standards; apparently, although its application to the state was tardy, Americare met those requirements. The agency decision to deny payment was based on an SRS

"policy" effective March 15, 1984, and announced in the Kansas Medicaid/MediKan Bulletin:

> "REIMBURSEMENT RELATED TO OWNERSHIP CHANGES MODIFIED MARCH 15, 1984
>
> Effective March 15, 1984, SRS will not reimburse services in adult care homes not licensed by the Department of Health and Environment (H & E). This policy, consistent with Kansas law, requires that in cases of ownership change the new owner cannot be reimbursed for any days which follow ownership change that are prior to relicensure by H & E."

This "policy" was not adopted as a regulation, but was established by SRS after some facilities were found to be operating without licenses following an ownership change. While this policy is intended to prod new owners into prompt action in securing a license, the policy does not appear to take into account the principal purpose of the federal regulation: to provide continued services for beneficiaries and recipients, and guard them against interruption of coverage.

We agree with the district court that SRS erroneously interpreted the law when it held that the provider agreements were transferred but immediately became void in the hands of the new owner. Federal law preempts state law to the extent that state law conflicts with federal law. *Ray v. Atlantic Richfield Co.*, 435 U.S. 151, 158, 55 L. Ed. 2d 179, 98 S. Ct. 988 (1978). The preemption doctrine applies to regu-

lations as well as statutes. *Capital Cities Cable, Inc. v. Crisp*, 467 U.S. 691, 81 L. Ed. 2d 580, 104 S. Ct. 2694 (1984). The intent of the federal agency in enacting the automatic transfer regulation was clearly to avoid lapses in coverage when a facility changes ownership. Allowing the State to withhold payments squarely defeats that purpose. We conclude that the federal regulation is controlling, and, under the specific facts of this case, we hold that Americare Properties, Inc., is entitled to recover Medicaid reimbursement in the amount of $106,928.29, plus interest and costs.

One other issue remains. The district court awarded attorney fees to Americare. K.S.A. 77-622 governs the relief available upon the appeal of agency decisions. Subsection (c) allows the court to award attorney fees only to the extent expressly authorized by other law. K.A.R. 30-10-12(b)(4)(A)(ii)(cc) (1983, revoked May 1, 1985), cited by the trial court in its opinion as authority for the awarding of attorney fees, discusses costs related to the appeal. It does not specifically mention attorney fees, and does not provide for the recovery of such fees by the appellant. We conclude that attorney fees are not recoverable in this action.

The judgment of the district court awarding Americare relief in the amount of $106,928.29, plus interest and costs, is affirmed; the judgment permitting recovery of attorney fees is reversed.

IN THE SUPREME COURT
OF THE STATE OF KANSAS

Americare Properties, Inc., d/b/a Russell Kare Center and Alafern Nursing Home, Appellee,	)	
v.	)	No. 86-60044-AS
State Appeals Committee, Kansas State Department of Social and Rehabilitation Services, Appellant.	)	

You are hereby notified of the following action taken in the above entitled case:

Motion by Appellees, Americare Properties, Inc., for modification.

The motion for modification is DENIED, without prejudice to Appellees to make claim for reasonable attorneys fees as allowable costs related to patient care under administrative regulations and the Medicaid Reimbursement System.

Application by Appellant for extension of time to respond to motion for modification.

Noted. Response already filed and considered.

Motion by Appellant, State Department of Social and Rehabilitation Services, for rehearing.

DENIED.

Date July 9, 1987

Yours very truly,
LEWIS C. CARTER
Clerk, Supreme Court

APPENDIX D

Article VI, ch. 2, Constitution of the United States.

> Supreme law of land. This Constitution, and the laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

42 U.S.C. Section 1396a(a)(13)(A) (1984)

> (a) A state plan for medical assistance must:
>
> (13) provide—
>
> (A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title)), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent

with section 1395x(v)(1)(G) of this title), which the States finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, skilled nursing facility, and intermediate care facility and periodic audits by the State of such reports; and

42 U.S.C. Section 1396d(c)

(c) *Intermediate care facility*

For purposes of this subchapter the term "intermediate care facility" means an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, (2) meets such

standards prescribed by the Secretary as he finds appropriate for the proper provision of such care, (3) meets such standards of safety and sanitation as are established under regulation of the Secretary in addition to those applicable to nursing homes under State law, and (4) meets the requirements of section 1395x(j)(14) of this title with respect to protection of patients' personal funds. The term "intermediate care facility" also includes any skilled nursing facility or hospital which meets the requirements of the preceding sentence. The term "intermediate care facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to institutional services deemed appropriate by the State. The term "intermediate care facility" also includes any institution which is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of clauses (2), (3), and (4) of this subsection and providing the care and services required under clause (1). With respect to services furnished to individuals under age 65, the term "intermediate care facility" shall not include, except as provided in subsection (3) of this section, any public institution or distinct part thereof for mental diseases or mental defects.

Kansas Statutes Annotated 39-926.

39-936. *License required to operate home; compliance with regulations.*

It shall be unlawful for any person or persons acting jointly or severally to operate an adult care home within this state except upon license first had and obtained for that purpose from the secretary of health and environment as the licensing agency upon application made therefor as provided in this act, and compliance with the requirements, standards, rules and regulations, promulgated under its provisions.

Kansas Statutes Annotated 39-938.

39-938. *Issuance of license, when; inspections and investigations; reports; renewability; nontransferable; display; contents of license.*

Upon receipt of an application for license, the licensing agency with the approval of the state fire marshal shall issue a license if the applicant is fit and qualified and if the adult care home facilities meet the requirements established under this law. The licensing agency, the state fire marshal, and the county, city-counsel or multicounty health departments or their designated representatives shall make such inspections and investigations as are necessary to determine the conditions existing in each case and a written report of such inspections and investigations and the recommendations of the state fire marshal and the county, city-county or multicounty health de-

partment or their authorized agents shall be filed with the licensing agency. The licensing agency and the state fire marshal may designate and use county, city-county or multi-county health departments and local fire and safety authorities as their agents in making such inspections and investigations as are deemed necessary or advisable. Such local authorities are hereby authorized, empowered and directed to perform such duties as are designated. A copy of any inspection reports required by this section shall be furnished to the applicant.

A license, unless sooner suspended or revoked, shall be renewable annually upon filing by the licensee, and approval by the licensing agency and the state fire marshal or their duly authorized agents, of an annual report and application for renewal upon such uniform dates and containing such information in such form as the licensing agency prescribes. Each license shall be issued only for the premises and persons named in the application and shall not be transferable or assignable. It shall be posted in a conspicuous place in the adult care home. If application for renewal is not so filed, such license is automatically canceled as of the date of expiration. Any license granted under the provisions of this act shall state the type of facility for which license is granted, number of residents for whom granted, the person or persons to whom granted, the date, the expiration date and such additional information and special limitations as are deemed advisable by the licensing agency.

42 C.F.R. §440.150

§440.150 *Intermediate care facility services, other than in institutions for tuberculosis or mental diseases.*

(a) "Intermediate care facility services, other than in an institution for tuberculosis or mental diseases" means services provided in a facility that—

(1) Fully meets the requirements for a State license to provide, on a regular basis, health-related services to individuals who do not require hospital or skilled nursing facility care, but whose mental or physical condition requires services that—

(i) Are above the level of room and board; and

(ii) Can be made available only through institutional facilities;

(2) Has been certified to meet the requirements of Subpart C of Part 442 of this subchapter as evidenced by a valid agreement between the Medicaid agency and the facility for providing intermediate care facility services and making payments for services under the plan; and

(3) Meets the conditions of Subpart E of Part 442 of this subchapter.

(b) "Intermediate care facility services" include services—

(1) Considered appropriate by the State and provided by a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston Mass.; or

(2) Provided by a facility located on an Indian reservation that—

(i) Furnishes, on a regular basis, health-related services; and

(ii) Is certified by the Secretary to meet the standards in Subpart E of Part 442 of this subchapter.

(c) "Intermediate care facility services" may include services in an institution for the mentally retarded or persons with related conditions if—

(1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions;

(2) The institution meets the standards in Subpart E of Part 442 of this subchapter; and

(3) The mentally retarded recipient for whom payment is requested is receiving active treatment as defined in §435.1009.

(d) "Intermediate care facility services" may include services provided in a distinct part of a facility other than an intermediate care facility if the distinct part—

(1) Meets all requirements for an intermediate care facility;

(2) Is an identifiable unit, such as an entire ward or contiguous ward, a wing, floor, or building;

(3) Consists of all beds and related facilities in the unit;

(4) Houses all recipients for whom payment is being made for intermediate care facil-

ity services, except as provided in paragraph (e) of this section;

(5) Is clearly identified; and

(6) Is approved in writing by the survey agency.

(e) If a State includes as intermediate care facility services those services provided by a distinct part of a facility other than an intermediate care facility, it may not require transfer of a recipient within or between facilities if, in the opinion of the attending physician, it might be harmful to the physical or mental health of the recipient.

(f) Intermediate care facility services may include services provided in a swing-bed hospital that has an approval to furnish intermediate care services.

[43 FR 45224, Sept. 29, 1978, as amended at 47 FR 31532, July 20, 1982]

42 C.F.R. §442.14

§442.14 *Effect of change of ownership.*

(a) *Assignment of agreement.* When there is a change of ownership, the Medicaid agency must automatically assign the agreement to the new owner.

(b) *Conditions that apply to assigned agreements.* An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued, including, but not limited to, the following:

(1) Any existing plan of correction.

(2) Any expiration date.

(3) Compliance with applicable health and safety standards.

(4) Compliance with the ownership and financial interest disclosure requirements of §§455.104 and 455.105 of this chapter.

(5) Compliance with civil rights requirements set forth in 45 CFR Parts 80, 84, and 90.

(6) Compliance with any additional requirements imposed by the Medicaid agency.

[45 FR 22936, Apr. 4, 1980]

442 C.F.R. §447.253(b)(1)(i)

§447.253 *Other requirements.*

(b) *Findings.*

(1) *Payment rates.* (i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

Kansas Administrative Regulation 28-39-77(d)

(d) Change in ownership. The licensee shall notify the licensing agency of any anticipated change in ownership information which differs from that on the current license application form. This notice shall be submitted 60 days in advance of the proposed effective date of the change. A change of ownership shall not take effect prior to the issuance of a license to the new owner by the licensing agency.

No. 87-547

In the Supreme Court of the United States

OCTOBER TERM, 1987

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES OF KANSAS,
Petitioner,

vs.

AMERICARE PROPERTIES, INC. d/b/a Russell Kare Center and Ala Fern Nursing Home,
Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF KANSAS

BRIEF FOR THE RESPONDENT IN OPPOSITION

EUGENE T. HACKLER, #04105
(*Counsel of Record*)
ROBERT C. LONDERHOLM, #04971
HACKLER, LONDERHOLM, CORDER, MARTIN & HACKLER, CHARTERED
201 North Cherry
P.O. Box 1
Olathe, Kansas 66061
(913) 764-8000
Counsel for Respondent

E. L. MENDENHALL, INC., 926 Cherry Street, Kansas City, Mo. 64106, (816) 421-3030

QUESTIONS PRESENTED FOR REVIEW

I. Whether the overall objectives of Congress under Title XIX (Medicaid) and implementing regulations are aimed at assuring continuity of coverage as being in "the best interest of" the beneficiaries and recipients and, as such, they preempt the obstacle posed by the purported state law.

II. Whether the Department of Health and Human Services was acting clearly within the scope of its delegated authority in promulgating the regulation providing for automatic transfer of provider agreements in transfer of ownership situations.

PARTIES

The parties are:

Petitioner:

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES OF KANSAS.

Respondent:

AMERICARE PROPERTIES, INC., d/b/a Russell Kare Center and Ala Fern Nursing Home.

[THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT appeared as Amicus Curiae in the Supreme Court of Kansas proceedings.]

TABLE OF CONTENTS

TABLE OF AUTHORITIES

A. CASES:

B. STATUTES AND REGULATIONS:

Internal Revenue Regulations

C. OTHER AUTHORITIES:

STATEMENT OF THE CASE

The Respondent, Americare Properties, Inc., purchased two nursing homes in Russell, Kansas on September 30, 1984. At the time of the purchase, both homes were in operation and licensed under Kansas law as "adult care" homes of the "intermediate care" classification. They were providing care and services to some Medicaid eligible patients under existing medicaid Provider Agreements as certified medicaid providers at the time of the transfer of ownership.

In cases of a transfer of ownership of a licensed nursing home, licensure law requires the new owner to obtain a license, i.e.; the existing license is not transferable. Respondent applied for two new licenses which were subsequently granted on November 26, 1984. Petitioner, however, totally denied medicaid reimbursement for the period from October 1, through November 25, 1984, in the amount of $106,928.29 on the basis that "the Kansas medicaid program does not reimburse for adult care homes who are not licensed by the Department of Health and Environment" (the Kansas licensure agency).

On August 31, 1984, the former owners of the two nursing homes had notified the licensure agency, the Department of Health and Environment, of the impending sale of the homes and that agency responded with a letter dated September 10, 1984, which stated, in part, "as the current operator, you will be responsible for the operation of the facility until we issue a license to the new owner."

It was not disputed that respondent continued to provide proper care and services to the medicaid residents in the nursing homes during the period from October 1, 1984 through November 25, 1984, nor was there a dispute

over the amount that was to be paid under the terms of the Provider Agreements for the services rendered. There was no proceeding commenced to cancel or revoke the existing licenses of either home during this period. The reimbursement was denied based upon a document entitled a "Policy Memorandum" (see Appendix B) issued by Petitioner on March 15, 1984, which stated in part that "medical programs will not be reimbursed for services provided by an adult care home that is not licensed . . . . New owners will not be reimbursed for days that the facility is not licensed for (sic)."

The federal regulation involved here, which will be discussed hereinafter, was adopted by the Health Care Financing Administration of the Department of Health, Education and Welfare (now, the Department of Health and Human Resources) in 1980. In essence, it addressed the specific question of how to handle the matter of providing for medicaid payments in cases where there was a "change of ownership" of the nursing home, but for some reason not involving the denial of a license to the new owner, there was a potential "gap" in the licensure of the home due to particular state laws which did not allow a transfer of existing licenses.

The federal regulation resolved the issue by providing that there would be an automatic transfer of the provider agreements so as not to create a coverage gap for the medicare and medicaid beneficiaries and recipients, with all applicable state laws and regulations to continue to apply.

Respondent appealed the denial of reimbursement pursuant to state administrative remedy procedures, and an administrative hearing officer upheld the denial on the theory that, although the provider agreement did auto-

matically transfer as required by the federal regulation, it became, *eo instanti*, "null and void". This ruling was appealed to the state District Court which held that the federal regulation preempted the Petitioner's "policy memorandum", which ruling was subsequently upheld by the Kansas Supreme Court.

Respondent would disagree with statements in Petitioner's Statement of the Case that it (respondent) "changed staff" at the nursing home "since September 1", and that it did not identify for licensure the "administrator of one facility" or that it "failed" to submit ownership information. *Petition*, pp. 3, 4.

REASONS FOR DENYING THE WRIT

ARGUMENT

I. The Overall Objectives of Congress Under Title XIX (Medicaid) and Implementing Regulations Are Aimed at Assuring Continuity of Coverage As Being in "the Best Interest of" the Beneficiaries and Recipients and, As Such, They Preempt the Obstacles Posed by the Purported State Law.

This Court has frequently reiterated that state law is preempted if it "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Pacific Gas & Electric Co.*, slip op. 11 (quoting *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941)); *Fidelity Federal Savings & Loan Ass'n.*, 458 U.S. at 153; *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. at 142-143; *Goldstein v. California*, 412 U.S. 546. When

Congress enacted the Medicaid provisions granting aid to the states for medical assistance programs it required the adoption in each state of an approved State Plan wherein federal regulations would be controlling. 42 U.S.C. §1396, et seq. While recognizing that necessary safeguards should be provided under the State Plan to assure eligibility for care and services, the Act further requires that such care and services be provided "in a manner consistent with simplicity of administration *and the best interests of the recipients.*" 42 U.S.C. §1396a(a)(19), emphasis supplied.

Therefore, the general underlying theme and *intent* of the Congress in enacting this legislation was to insure that the benefit of the *federal* funds granted reach the eligible beneficiaries and recipients and assure that the needed care and services be provided in the most efficient, simplified manner. This requirement of "in the best interest of" thus provides the general intent and basic purpose against which all the detailed federal and state law provisions involved in this case must be measured.

This petition involves a very narrow and confined factual circumstance which may arise in cases of a "change of ownership" of an existing, previously licensed and operating health care facility (in this case, two "intermediate care facilities"), where there is a temporary, technical gap in state licensure coverage arising between the time the former, licensed owner sells the facility and the new owner receives a new license. It does *not* involve a situation where there has been a *denial* of a license to the new owner, nor a *failure* to obtain a license in the first instance.

In this narrow type of factual setting, it is presumed that the new owner would *not* go to the considerable time,

effort and expense of purchasing an established nursing home without fully intending to and in fact proceeding to comply with all necessary requirements for continued operation of the home (as happened here). The federal agency charged with administering the medical and medicare laws (The Department of Health and Human Resources, herein "HHR") recognized from experience the practical problem that arises where a particular state's law requires a new owner to immediately obtain a new license, but there arises those inevitable cases where an administrative delay (not a *denial*) might occur in obtaining the new license. The question then arises as to whether this temporary situation should operate so as to automatically cut off benefits to the home and its already resident beneficiaries and recipients.

HHR has sought to *balance* the *general* recognition of the validity of state licensure law in the federal law (Social Security Act) with the *specific* intent of that law that the *best interests* of the beneficiaries and recipients should be served and simplicity of administration of the law preserved. It did so by the 1980 promulgation of 42 C.F.R. 442.14, providing that medicaid payments should continue during such temporary period, while recognizing that if the new owner is then *denied* a license, the payments may be terminated. This Court has held that in such cases, the inquiry becomes whether the federal agency's action " 'represents a reasonable accommodation of conflicting policies' ". *Fidelity Federal Savings and Loan Ass'n.*, supra, at 154.

HHR has implemented this underlying purpose and intent by duly adopted regulations which focus on this specific, narrow area involved where there is a *change in the ownership* of the health care facility without seek-

ing to "supercede" the overall state licensure requirements by requiring that payments continue under the existing "Provider Agreements." Provider Agreements are entered into between the appropriate state agency, in this case, the Kansas Department of Social and Rehabilitation Services (SRS) and the provider of the services, in this case, the two intermediate care facilities located in Russell, Kansas. These Provider Agreements are mandated by federal law and regulation as the vehicle or conduit by which the funds are transferred on down from the state to the particular providers of the care and services for the eligible medicaid beneficiaries residing in their facilities. Although the state was not required to participate in the medicaid program, once it has voluntarily elected to do so, it must comply with federal standards. *Country Club Home, Inc. v. Harder,* 228 Kan. 756, 620 P.2d 1140.

The Provider Agreements are normally entered into for a term of months, as required by federal regulation (42 C.F.R. Section 442.12), and in the present case the relevant Agreements were for the terms of June 1, 1984 through March 31, 1985 (Ala Fern Nursing Home) and July 1, 1984 through June 30, 1985 (Russell Kare Center) respectively. Thus, the stated terms of the two Agreements completely envelope the payment period which SRS sought to dispute and deny, i.e.; the seven and one half week period from October 1, 1984 through November 25, 1984, the day before the licenses were later granted by SRS, with no claim made by SRS that proper care and services were not furnished during the interim period.

In 1980, HHS duly promulgated regulations which, in part, carefully addressed this "transfer of ownership" situation vis-a-vis existing Provider Agreements. See 42

C.F.R. 442.14. Specifically, as shown by the plain wording of the Regulation itself, as well as by the comments quoted in the Federal Register as part of the agency's proposed ruling making procedure (see *Federal Register*, Vol. 45, No. 67, pp. 22933 through 22935, attached hereto as Appendix A), HHS was consciously concerned about any gap which might result in a "change of ownership" situation if payments under Provider Agreement or payments thereunder were interrupted or terminated solely by reason of such ownership change.

This concern by HHS clearly centered upon "protecting beneficiaries" from possible adverse effects of any such "coverage gap", by providing for an *automatic assignment* of the Provider Agreement. This concern will be further demonstrated by the quotations and discussion below. At the same time, it is readily apparent that the federal agency sought to craft the new regulations in such a way as to permit and preserve legitimate safeguards for the protection of the "health and safety" of the Medicaid beneficiaries during change of ownership situations. The Regulation was patently drawn by HHS to carry out the overriding concern and mandate of the Federal Act and Congress to protect "the best interests of the recipients" by, on the one hand, avoiding "interruption of coverage", and, on the other, by providing or recognizing the continued applicability of safeguards *reasonably related* to protecting the "health and safety" of the residents and decreasing the "risk of fraud and abuse". This 1980 Regulation provided:

> §442.14 Effect of change of ownership.
>
> (a) *Assignment of agreement. When there is a change of ownership, the Medicaid agency must automatically assign the agreement to the new owner.*

(b) *Conditions that apply to assigned agreements.* An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued, including, but not limited to, the following:

(1) Any existing plan of correction.

(2) Any expiration date.

(3) Compliance with applicable health and safety standards.

(4) Compliance with the ownership and financial interest disclosure requirements of §§455.104 and 455.105 of this chapter.

(5) Compliance with civil rights requirements set forth in 45 CFR Parts 80, 84 and 90.

(6) Compliance with any additional requirements imposed by the Medicaid agency.

45 F.R. 22933, dated April 4, 1980. Emphasis supplied.

An analysis of the above Regulation shows that it serves the two objectives cited above in that subpart "a" averts the detrimental "coverage gap" in payments by mandating an automatic transfer of the Provider Agreement to the new owner, while subpart "b" preserves and recognizes all the other terms and conditions of the Agreement originally issued, including compliance with health and safety standards and existing plans of corrections. The Regulation also preserves recognition of the existing expiration date, and explicitly recognizes the need of the new owners to pursue compliance with requirements for ownership and financial disclosure requirements as well as civil rights compliance.

It is also pointed out that this Regulation makes reference to the Federal Register, 45 F.R. 22934, dated April 4, 1980, which is set out in part in Appendix "A" attached hereto. The Federal Register states in numbered paragraph 2, as follows:

> "2. *Assignment of Provider Agreement Where There Is A Change of Ownership.* Under the proposed rules Medicare and Medicaid Provider Agreements would be automatically assigned to the new owner, subject to all the terms and conditions under which the original agreement was issued. *This approach would make Medicare and Medicaid practices uniform."* Emphasis supplied.

Further analysis of comments in the Federal Register relevant to automatic changes of ownership shows the HHS expressly addressed and considered concerns about the "automatic transfer" provision in change of ownership situations:

> "*Analysis of Public Comments*:
>
> We received 24 comments on the February 5, 1979 Notice of Proposed Rulemaking. Most comments were favorable and recognized the need for the regulations. They were addressed primarily to whether the effective date of provider agreements should be based on the onsite survey date or the date of request for participation; whether the effective date rules apply only to initial certifications; *whether assignment should be automatic on change of ownership; and whether assignment conflicts with other regulations."* Introduction and para. 2, 45 F.R. 22934; Emphasis supplied.

And, in responding to a question regarding whether or not the assignment of the provider agreements would be automatic, the Department of Health and Human Services said as follows:

> "* Some State laws prohibit transfer of a license to a new owner. A new license is issued only after an onsite inspection. Since Federal regulations require compliance with State and local laws, some States would be violating their own rules." Id., at p. 22935.

Continuing, the Federal Register states:

> "Response: We realize that the State survey agency often learns of a change of ownership after the fact. We also acknowledge that there may be some unscrupulous owners who might take advantage of the situation. But we do not agree that this is the norm. Our primary goal is to protect beneficiaries and recipients against interruption of coverage. We believe the following safeguards will protect their health and safety and decrease the risk of fraud and abuse."
>
> * "The regulations do not prevent the State survey agency from going in at any time either under the Medicare/Medicaid authority or the authority of State licensure laws."
>
> * "All providers are required to be in compliance with State and local laws as a condition of participation. If the State, *after a licensure survey* refuses to issue a license because of non-compliance with State law, the facility would no longer be eligible to participate in the Federal programs. *It must be remembered that the regulation refers to transfers of provider agreements and not to transfers of State licenses.*" Id., p. 22935; emphasis supplied.

It is clear from the above legislative history of the adoption of this Regulation that HHS gave specific and careful consideration of all the various factors and concerns involved, and then deliberately opted for the approach now reflected in 42 C.F.R. 442.14, quoted above. In so doing, HHS was acting within the manifest intent of Congress to protect the "best interests" of the welfare recipients in these health care institutions. As noted, its action deals expressly with transfers of a *provider agreement* in the narrow circumstance of a change of ownership; it does not deal with or impact in any substantive manner with the matter of state licenses or the transfer thereof. As such, this Regulation and the Congressional intent which it serves clearly preempts any contrary state law, regulation or "policy" statement.

It is likewise obvious that the purported "Policy Memorandum" prepared in 1984 by the Kansas Department of Social and Rehabilitation Services stands as an "obstacle" to and directly "frustrates" the accomplishment and execution of the intent of the federal law and this regulation. *Pacific Gas and Electric Co.*, supra; *Savage v. Jones*, 225 U.S. 501.[1] This "policy" statement purports to deny any medicaid reimbursement to new owners of licensed facilities during any "gap" period which might occur between the date that ownership of the facility is transferred as between the former, licensed owner and the "new owner" and the date that the new owner receives the new

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1. State laws "may not frustrate the operation and purpose of federal law". *Savage v. Jones*, 225 U.S. at 507. The Chief Hearing Officer who conducted an administrative hearing within the state agency sought to *avoid* the conflict by the sophistry of declaring that the provider agreements were "automatically assigned to the new owners" but *once assigned* "became null and void", thus neatly eviscerating the whole purpose of the federal regulation. *Petition*, p. A24.

state license for the faciilty. Therefore, the "policy memorandum", which is most arguably not authorized under state law as well (see discussion below), flies directly in the face of the deliberate federal policy to avoid "coverage gaps" in medicaid reimbursement for non-substantive reasons arising solely from legal transfers of ownership, where no threat to the health and safety of medicaid residents is involved.[2] Application of the federal preemption doctrine under the Supremacy Clause of the United States Constitution (Article VI, cl. 2) is clearly called for in this situation, and the Kansas Supreme Court and Kansas District Court correctly so ruled.

A. The Federal Preemption Doctrine Applies Equally to Validly Adopted Federal Regulations Such As 42 C.F.R. 442.12.

Although the overall intent of Congress to protect the "best interests" of the medicaid beneficiaries arises from the language of the federal statute, and that language would be *per se* sufficient to preempt the state policy memorandum involved here, it is also true that the Federal Regulation involved (42 C.F.R. 442.12) has the same force and effect as a federal law in terms of the application of the federal preemption doctrine. As this Court stated in *Fidelity Savings and Loan Ass'n.*, 458 U.S. at 153: "Federal regulations have no less preemptive

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2. Of course, if a threat to the health and safety of the residents exists or arises during the time of the transfer of ownership and transfer of licensure period, the state has ample tools available to take appropriate corrective action; denial of medicaid reimbursement during such periods obviously is not aimed at nor would it bear any reasonable relationship to preventing such threats to health and safety. If anything, just the opposite would be true, i.e. cutting off needed funds might impair the facilities' ability to adequately care for the residents.

effect than federal statutes." See also *Blume v. Bacon,* 457 U.S. 132 (1982); *Free v. Bland,* 369 U.S. 663, 668 (1962); *United States v. Shimer,* 367 U.S. 374, 381-382 (1961). The Secretary of Health and Human Resources has been delegated authority to promulgate rules and regulations to carry out the purpose and intent of the federal statute. The particular regulation involved here (42 C.F.R. 442.14) falls within the scope of the delegated authority of the Secretary to make rules and regulations to carry out the overall intent that the "best interests" of the welfare recipients be served by the program.

The Petitioner complains that the Supreme Court of Kansas "considered *only* particular *regulation* intents (sic) to rule that 42 C.F.R. and its subsection (a) superceded stated licensure requirements . . . ." *Petition,* p. 8; emphasis by Petitioner and in part added; material in parentheses supplied.

The *implication* from the above quoted language appears to be that federal *regulations,* and the clear *intent* of *their* language, are of *lesser* stature that federal laws, and therefore may be safely ignored or disregarded in analyzing whether there is federal preemption on a particular matter. As noted above, validly adopted federal regulations promulgated by the agency charged with the responsibility of carrying out the broad intent of Congress, are of *equal* force and effect with federal statutes in cases involving federal preemption.

Further, the Petitioner virtually admits, *sub silentio,* that a full and fair reading of the federal regulation and the accompanying legislative history as set forth in the Federal Register clearly demonstrates the HHS consciously and deliberately addressed the precise question

involved here—how to handle possible coverage gaps in medicaid payments under provider agreements in cases of ownership changes—and then it proceeded to resolve the question *adverse* to Petitioner's position here. Consequently, Petitioner seeks to duck the inevitable preemption consequence by somehow *demoting* federal regulations and their clearly expressed intent to some lesser status where, presumably, the preemption doctrine does *not* apply, even though there is a manifest conflict between the intent of the federal *regulation* and the state agency's "policy".

However, Petitioner does seek to rely upon a *selected* "part" of the comments and legislative history surrounding the 1980 adoption of the federal regulation contained in the Federal Register which Petitioner, erroneously, construes as supporting its position.

Petitioner argues that "*Part* of that (Federal Register) comment when considered with the statutory language of 42 U.S.C. §1396d(c) should be *controlling.*" *Petition*, p. 11; material in parenthesis and emphasis supplied. Thus, Petitioner studiously ignores and avoids any quotation from or discussion of these *specific* comments in the Federal Register which squarely address and resolve (adversely to Petitioner) the continuation of payments question in owner transfer cases where there is non-substantive, administrative gap in licensure (see quotation from Federal Register, Appendix "A"). The Federal Register "comment" which Petitioner does selectively single out and promote as "controlling" is the statement that: "It must be remembered that this regulation refers to *transfers of provider agreements* and *not* to *transfers of State* licenses.[3]

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3. *Petition*, p. 11, emphasis supplied; quoting from 45 F.R. 22935 (Apr. 4, 1980), and referring to the adoption of 42 C.F.R. 442.14(a).

Exactly! This comment, properly read along with the entire context of the comments accompanying the promulgation of the Regulation, clearly supports the position of the respondent here, rather than that of Petitioner.

As discussed above, the entire Regulation was carefully crafted to avoid, on the one hand, any conflict with or limitation on state *licensure* requirements while, on the other hand, carrying out the Congressional intent to protect the best interests of the medicaid recipients in cases of ownership transfer by providing for automatic *provider agreement* transfer (*not* license transfer) to avoid detrimental coverage gaps while the administrative procedure for the issuance of new licenses was being accomplished. The above quoted comment from the Federal Register simply points out this carefully circumscribed focus of the new Regulation aimed at *provider agreements only*, while disclaiming any intent to affect state licensure laws.

B. The Automatic Transfer of Provider Agreement Provisions of 42 C.F.R. 442.14(a) Do Not Purport to Preempt or Control State Licensure Laws Regarding Intermediate Care Facilities.

Petitioner's entire approach to this matter is based on an effort to posit this case on the ill founded supposition that the state licensure laws would be preempted or superceded by the HHS Regulation if provider agreements and payments thereunder are automatically continued during the relatively brief time frame when change of ownership procedures are taking place.[4]

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4. The Petitioner argues that "(n)one of (the) statutory and regulation (sic) framework indicates either an intent to preempt State licensure laws or to deprive medicaid recipients of their protections from (sic) such laws." *Petition*, p. 14; material in parentheses supplied.

The Petitioner charges, incorrectly, that the Kansas Supreme Court has *ruled* that the federal regulation "superceded state law *licensure requirements*", and then it proceeds to argue vehemently throughout that this case involves "preemption of state law *licensure* requirements".[5] Such is simply not the case; both the federal regulation involved and the Kansas Supreme Court decision construing and applying it focus solely on the very narrow and specific matter of transfer of *provider agreements* (not *state licenses*) in "change of ownership" procedures.

The Kansas Supreme Court properly analyzed the automatic transfer provisions of the federal regulation and found its "principal purpose" as "being to provide continued services for beneficiaries and recipients, and guard them against interruption of coverage" (*Petition*, p. A49). The Kansas Supreme Court also took due note of the fact that this federal regulation provides that "assigned agreements are subject to all applicable statutes and regulations and to the terms and conditions under which the original agreement was issued." (*Petition*, p. A47). The subject Regulation expressly notes six of these limiting conditions which continue to apply *after* the automatic assignment takes place, which list is not to be considered exclusive. See *Petition*, pp. 10, 11, for list.

The provisions which by federal regulation continued to apply to any automatic assignment carefully preserve those substantive provisions in the provider agreements relating to the health, safety and welfare of the residents,

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5. *Petition*, pp. 8, 10; emphasis added; at p. 13, Petitioner argues, without any rational factual foundation and contrary to existing statutes, that the federal regulation "leaves them without the protection of basic licensure requirements that are to be accorded to all other nursing home patients in the state."

while also addressing related concerns about ownership and financial interest disclosure, as well as civil rights.

The federal regulation was thus clearly worded so as not to restrict or preempt applicable state *licensure* statutes and regulations designed to protect the welfare of the beneficiaries and recipients. Further, promulgation of this federal regulation did not seek in any manner to impair the overall state policy that makes it "unlawful" to operate a nursing home facility without a license (K.S.A. 39-926). The Kansas Supreme Court opinion specifically recognizes the continued efficacy of this statute and additionally cites specific enforcement provisions or "teeth" in the Kansas statute, which make it a misdemeanor subject to fine and jail sentence to operate a nursing home (adult care home) without a license. (*Petition,* p. A47). The opinion notes also the state statutory provision that *licenses*[6] are not transferable, and that new owners are required by state regulations "to apply for" new provider agreements.

While the regulation of the Kansas Department of Social and Rehabilitation Services specifies that where there is a "change of provider" or a "change of ownership" of an adult care home having an existing provider agreement, an application to be a provider "shall be *submitted*" (K.A.R. 30-10-1b [b] and [c]), this regulation does not purport to say that payments under the *existing provider agreement* cease either automatically or within a set period of time, if a new provider agreement is not applied for or received by the exact date of the owner-

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6. The non-transferability statute (K.S.A. 39-928) refers specifically to "licenses", *not* to "provider agreements."

ship "change". All this regulation commands is that the new provider/owner "submit an application".[7]

This regulation was *properly* promulgated by SRS in accordance with the Kansas law requiring all administrative rules and regulations which seek to have "the effect of law" and to "govern" an agency's "enforcement or administration of legislation" to be adopted in a specified manner. This required procedure includes scrutiny by the state Department of Administration, a review for legal sufficiency by the Attorney General, notice to interested parties of a hearing and a hearing thereon. K.S.A. 77-415, et seq.

By contrast, the "Policy Memorandum" at issue here was *not* adopted by SRS in accordance with the above cited law governing promulgation of rules and regulations having "the effect of law", and it therefore falls into the subordinate category of being merely an "interpretation" of existing law (see K.S.A. 77-415 [4]). As such, this "Policy Memorandum" appears to be in direct conflict and inconsistent with the duly adopted state regulation cited above (K.A.R. 30-10-1b).

Therefore, a strong argument may be made that (1) the "Policy Memorandum" involved here does not even rise to the level of being a *state law* or *regulation* such as would trigger a preemption analysis of federal-state conflict of law under the Supremacy Clause, and (2) the "Policy Memorandum" itself is in conflict with a duly

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7. The Regulation does require either the "seller or prospective buyer to notify the agency at least sixty (60) days in advance of the proposed changed ownership", but the penalty for failure to notify is specific and limited to the "new owner assuming responsibility for any overpayment made to the old owner".

adopted state law (i.e.; SRS regulation 30-10-1b) which specifically covers and controls the subject of *provider agreements* (not state *licenses*) and changes of ownership.

Consequently, this entire dispute may well be resolved against Petitioner on a non-constitutional basis as a matter of the interpretation and interaction of purely state statutes and regulations, without even having to resort to resolution of a *constitutional* issue under the Federal Supremacy Clause. Treating the matter as a question of statutory interpretation without reaching a constitutional issue is, of course, the preferred handling of such cases. *Douglas v. Seacoast Products, Inc.*, 431 U.S. 265.

In addition to the various tools for enforcement of the state *licensure* mentioned by the Kansas Supreme Court which remain completely unscathed or unaffected by the federal regulations, there are a multitude of other state provisions for enforcement of laws relating to the licensed facilities, including (1) "injunctions or other process to restrain or prevent the operation of an unlicensed adult care home (K.S.A. 39-944), (2) the issuance of "correction order" in any case where "health, safety, nutrition or sanitation" is adversely affected, which order "shall specify *the time allowed for correction*"[8] (K.S.A. 39-945; emphasis supplied), (3) issuance of a "citation" and imposition of a monetary "civil penalty" for failure to correct deficiencies (K.S.A. 39-946) and (4) appointment of a "receiver" to

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8. Interestingly, the state statute implicitly acknowledges that even in cases where a violation imperiling "health or safety" is discovered, some reasonable *period of time* shall be allowed for correction thereof, and the implementing regulations permit up to six months or a year to accomplish compliance.

take over the operation of the home where (a) conditions that are life threatening or endangering exist, (b) insolvency or (c) license revocation by the secretary of health and environment. K.S.A. 39-954.

Against this backdrop of multiple licensure enforcement tools available—criminal prosecutions, injunctions, citations, civil penalties, receivership, licensure denial (for cause) and other means of control—the hollow claim of the Petitioner that this decision of the Supreme Court regarding its policy memorandum will "deprive Medicaid recipients of their protections from (sic) such (licensure) laws"[9] is simply empty rhetoric and wildly overblown. The intent of the federal regulation clearly recognizes that if the new owner's application for a license is subsequently *denied* for some substantive or valid reason, then continued provider payments may be terminated.[10]

It is not necessary that a federal law, either statute or regulation, contain an express provision manifesting an intent to preempt conflicting state laws, in order for the preemption doctrine to apply. *DeCanas v. Bica,* 424 U.S. 351. Even though there is no express statement in the federal law or regulation involved requiring automatic transfer of provider agreements which states in so many words that all state laws or regulations to the contrary are preempted, the doctrine nonetheless applies if the state law "frustrates" or creates an "obstacle" to the federal purpose—in this case, protecting the health, safety and best interest of the medicaid beneficiaries by preventing

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9. *Petition,* p. 14; emphasis supplied.

10. See *Comments* from Federal Register, Appendix A, p. A3.

a gap in coverage. Preemption may be either express or implied. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85.

Petitioner argues that the federal law "hardly indicates any intent for preemption of state licensure requirements."[11] This is plainly a further attempt to mis-characterize the scope of the federal regulation as some type of broad scale "attack" on state "licensure requirements" and then fight the case on a "battlefield" different from that actually presented under the facts and law. This regulation addresses the very narrow and limited issue of whether medicaid payments should or should not continue so as to cover any gap in coverage that might otherwise arise in the transfer of ownership administrative procedure. It is obvious from the comments accompanying the adoption of the regulation that the federal agency was cognizant of a potential conflict and it consciously resolved any such perceived conflict in favor of the overriding Congressional intent to protect the best interests of the medicaid recipients. Thus, an overt, *clearly expressed intent* to preempt in this narrow area is present in the federal regulation.

Both the state District Court and the Kansas Supreme Court clearly recognized the narrow and non-substantive area in which the federal regulation was intended to preempt state law: the District Court noted that it applied *only* to situations in which there might be a simple "delay" in getting a license, not a refusal of state licensure."[12] The Supreme Court referred to the limited situation as one where a new owner applicant might be "tardy" in apply-

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11. *Petition*, p. 9.

12. *Petition*, p. A37.

ing for the license, but nonetheless meet "those requirements".[13]

Both Kansas courts recognized the situation as one not involving any substantive threat to the health, safety or welfare of the residents, but one where the state agency, in a type of bureaucratic pique over "tardy" new owner applicants, was seeking to "punish" *them* for their delay in applying for a licensure replacement, by an irrevocable cancellation of provider payments during any such interim period (without regard to the possible "punishment" of medicaid recipients which might occur).

The Department of Health and Human Resources clearly anticipated the possible "conflict" that might arise in the limited *ownership transfer* situation. Without harming the basic state licensure structure in any way, the federal agency nevertheless "manifested" a clear intention to override any state law or policy which might be involved to "frustrate" the clear congressional mandate given the agency to protect the welfare of the medicaid recipients.

C. The Kansas Department of Social and Rehabilitation Services Lacked Jurisdiction to Issue the Policy Memorandum Ostensibly Aimed at Enforcing State Licensure Laws Administered by the Department of Health and Environment.

The licensing agency in the State of Kansas which issues and controls licenses for intermediate care facil-

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13. *Petition*, p. A48; the purported agency "policy", however, was more broadly drawn and would operate to automatically terminate provider payments in a situation where, for example, a sole proprietor licensee was unexpectedly killed in a car accident, thus cancelling the old license.

ities (adult care homes) is the Department of Health and Environment, acting through its Secretary (K.S.A. 39-923[a] [14]):

"39-923(a) As used in this act:

* * *

(14) 'Licensing agency' means the secretary of health and environment."[14]

The Petitioner in this case, however, is the Department of Social and Rehabilitation Services of Kansas (SRS), a separate state agency.[15] It is this agency (SRS), and *not* the state licensure agency, the Department of Health and Environment (KDHE), which issued the "Policy Memorandum" involved here.

Petitioner, the Department of Social and Rehabilitation Services, neither issues, renews, denies, suspends or revokes licenses issued to "intermediate care facilities", nor does it otherwise control or regulate the state licensure laws procedure. Nevertheless, Petitioner has elected in its Petition to base its request for the granting of a writ of certiorari on the sole argument that the 1980 federal regulation involved threatens and attempts to "supersede state law licensure requirements" contrary to "Congressional intent".[16] Petitioner insists that it is for

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14. See Chapter 75, Article 56, Kansas Statutes Annotated, for laws creating and regulating the Department of Health.

15. See Chapter 75, Article 53, for law creating and regulating the Department of Social and Rehabilitation Services.

16. Petitioner's argument in support of its reason for granting the writ commences:

> "Neither the opinion of the Supreme Court of Kansas, nor the affirmed and quoted opinion of the state District Court consider the provisions of 42 U.S.C. 1396d(c) and its recognition of the requirement to be "licensed under State law" before construing a subordinate federal regulation to supersede state law licensure requirements." *Petition*, p. 7.

this reason, i.e.; protecting the "state *licensure* procedures," that it issued its March 15, 1984 "policy memorandum" cutting off medicaid payments in situations where a new state license was not issued for an existing facility on or before the date of an "ownership change".

However, the appropriate state agency to promulgate regulations (or "policies") enforcing the state licensure laws would be the licensing agency itself, the Department of Health and Environment. That state agency did not see fit to promulgate or, at a minimum, cosponsor such a regulation.

Consequently, SRS *lacked jurisdiction* to promulgate a regulation or policy under the guise or purported authority of "protecting" the "state licensure laws". This further illustrates the transparency of Petitioner's ill founded claim that the federal regulation "superceded" state license requirements, which it (SRS) was seeking to enforce.

II. The Department of Health and Human Services Was Acting Clearly Within the Scope of Its Delegated Authority in Promulgating the Regulation Providing for Automatic Transfer of Provider Agreements in Transfer of Ownership Situation.

The Department of Health and Human Resources (formerly Health, Education and Welfare) was acting clearly when the scope of its delegated authority to promulgate rules and regulations designed to carry out the Congressional intent that the Medicaid and Medicare programs protect the "best interests" of the beneficiaries and recipients under a joint federal state program to be carried out in a simple and efficient manner. 42 U.S.C. §1396a(a)(19). Petitioner claims a lack of "power" on

the power of HHR to have promulgated the regulation in question, ostensibly asserting a lack of congressionally delegated authority. The agency is expressly granted authority to promulgate rules and regulations, and this particular regulation is firmly premised on the intent of Congress to protect in the last analysis the welfare and best interests of the beneficiaries and recipients of these federally supported programs.

Petitioner likewise chastises the Kansas Supreme Court for its alleged failure to "address" the question of whether Congress intends that the federal regulation supercede state law and to "address" a *presumption* that "matters related to health and safety" are not to be superceded by federal law, citing two United States Supreme Court decisions, *Louisiana Public Service Comm. v. FCC*, 476 U.S. ....., 106 S. Ct. 1890; *Hillsborough County v. Automated Med. Labs*, 471 U.S. 707.

While respondent has no quarrel with the general proposition of law stated in those two decisions, neither is apropos on the facts or law to the situation involved in this application for writ. Petitioner has simply attempted to select the wrong battleground on which to fight this case. Having wrongly characterized this case as one in which the federal regulation seeks to overthrow or "supercede" state licensure requirements on the one hand, while mistakenly identifying its purported "policy" as being designed to "protect" the "health and safety" of beneficiaries and recipients,[17] Petitioner then proceeds to argue from cases not applicable to the matter at hand.

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17. Just the opposite is true, cutting off medicaid support for no reason related to any showing of a threat to the health or welfare of the recipients potentially imperils their welfare, as previously discussed.

Obviously, both the Kansas Supreme Court and the state District Court took a careful look at the intent of Congress, quoting not only the particular regulation adopted but also citing comments accompanying its promulgation which made it clear that automatic transfer of provider agreements was the desired intent and option elected, soundly based on the desire to protect the best interests of the welfare recipients.

By the same token, the Supreme Court opinion also recognized and confirmed the "health and safety" aspects of the case and concluded that the interests of the recipients and beneficiaries outweighed the spuriously adopted policy of SRS to "prod new owners into prompt action"[18] on a non-substantive, administrative procedure. In so doing, the Supreme Court pointed out specfically that it was the *state* agency which was ignoring or seeking to avoid the clearly expressed federal intent in the matter, to-wit: "(T)he (SRS) policy does not appear to take into account the principal purpose of the federal regulation: to provide continued services for beneficiaries and recipients, and guard them against interruption of services."

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18. *Petition*, p. A49.

CONCLUSION

The Department of Health and Human Resources promulgated the regulation involved here with the clear intent of carrying out the Congressional mandate to protect the best interest of the medicare and medicaid beneficiaries and recipients. It had the lawfully delegated authority to do so in a simplified administrative program. Its regulation is aimed at a very narrow, factual situation and does not threaten or impede overall state licensure requirements. The state "policy" involved is of questionable validity under state law, and was beyond the jurisdiction of the particular state agency involved.

For the reasons stated above, the Petition For Writ of Certiorari should be denied.

Respectfully submitted,

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APPENDIX

APPENDIX A

Federal Register

Vol. 45, No. 67 / Friday, April 4, 1980 / Rules and Regulations

(Pages 22933-22935)

* * *

SUMMARY: These regulations revise and redesignate the policies pertaining to provider agreements under the Medicare program to simplify them and to make them easier to read. We have made substantive changes only in the provisions relating to the effective date of the agreement and the effect of a change in ownership. These substantive changes were issued as proposed rulemaking on February 5, 1979, and will also apply to the Medicaid program.

* * *

* * * The revised regulations also provide that existing provider agreements be assigned to new owners, subject to the terms and conditions under which they were originally issued.

The intent of the substantive changes is to achieve maximum uniformity of policy for the two programs and to provide continuity of coverage for beneficiaries and recipients when there is change of ownership.

* * *

Medicare and Medicaid had developed different practices for the effective date of provider agreements. * * * These revised rules establish uniform policy on effective dates.

Medicare and Medicaid also dealt differently with changes of ownership. Both Medicare and Medicaid issued new agreements. However, Medicare permitted the agreement to be backdated to the date the previous agreement was terminated. Under Medicaid, a new survey was usually made and a new agreement issued effective on the date compliance was determined. The difference could result in a coverage gap for Medicaid recipients. These revised rules provide for assignment of agreements to new owners in both programs.

* * *

2. *Assignment of Provider Agreement When There Is Change of Ownership.* Under the proposed rules, Medicare and Medicaid provider agreements would be automatically assigned to the new owner, subject to all the terms and conditions under which the original agreement was issued. This approach would make Medicare and Medicaid practices uniform. * * *

* * *

Analysis of Public Comments:

We received 24 comments on the February 5, 1979, Notice of Proposed Rulemaking. Most comments were favorable and recognized the need for the regulations. They were addressed primarily to whether the effective date of provider agreements should be based on the onsite survey date or the date of request for participation; whether the effective date rules apply only to initial certifications; whether assignment should be automatic on change of ownership; and whether assignment conflicts with other regulations.

* * *

Response: The regulations have been modified to clarify that in recertification of long-term care providers,

the new agreement becomes effective when the existing agreement expires. * * *

* * *

* Some State laws prohibit tranfer of a license to a new owner. A new license is issued only after an on-site inspection. Since Federal regulations require compliance with State and local laws, some States would be violating their own rules.

* * *

Response: We realize that the State survey agency often learns of a change of ownership after the fact. We also acknowledge that there may be some unscrupulous owners who might take advantage of the situation. But we do not agree that this is the norm. Our primary goal is to protect beneficiaries and recipients against interruption of coverage. We believe the following safeguards will protect their health and safety and decrease the risk of fraud and abuse.

* * *

* The regulations do not prevent the State survey agency from going in at any time either under the Medicare/Medicaid authority or the authority of State licensure law.

* * *

All providers are required to be in compliance with State and local laws as a condition of participation. If the State, after a licensure survey, refuses to issue a license because of non-compliance with State law, the facility would no longer be eligible to participate in the Federal programs. It must be remembered that this regulation refers to transfers of provider agreements and not to transfers of State licenses.

* * *

APPENDIX B

POLICY MEMORANDUM

TO: James G. Hall, EDS-Federal

FROM: L. Kathryn Klassen, R.N., M.S.

DATE: February 21, 1984

RE: Policy Non-Payment of ACH's not Licen

Rate Change

Control # 406

Processing Procedure

Effective 3-15-84, Medical Programs will not reimburse for services provided by an Adult Care Home that is not licensed. According to State Law, all Adult Care Homes have to be licensed in order to be reimbursed. New owners will not be reimbursed for days not licensed.

Rationale for change:

Federal regulations require states to transfer the previous owners provider agreement whenever a change of ownership occurs. State regulations require a facility to be relicensed whenever a change of ownership occurs.

Recently, we have had several providers who have called and stated "we took over 2-1-84," and the Dept. of Health & Environment has not licensed their facility because they got notice of the change the same time SRS did. (Continued On Reverse Side)

The following will become effective _____ service date or _____ processing date; requiring ____ provider notification, ____ provider manual change, _____ Medical Assistance manual change, ____ processing manual change.

Effedtive 3-15-84, Medical Programs will not reimburse for services provided by an Adult Care Home that is not licensed. According to State Law, all Adult Care Homes have to be licensed in order to be reimbursed. New owners will not be reimbursed for days that the facility is not licensed for.

3-2-84
Date

L. Kathryn Klassen
L. Kathryn Klassen, R.N,M.S.
Director of Medical Programs

Sent to:

	Yes	No	Comments Made:
IM Chiefs	☐	☐	
SS Chiefs	☐	☐	
Area Managers	☐	☐	

Policy Committee Action: Approved 2/28/84

John Schneider
John Schneider, Commissioner
Income Maintenance & Medical Services